Health Education England

Barking, Havering and Redbridge University Hospitals NHS Trust

Gastroenterology

Risk-based review (on-site visit)

Quality Review report

11 December 2018

Final Report

Developing people for health and healthcare

www.hee.nhs.uk

THE NHS CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	This was the fourth Health Education England (HEE) quality review of the gastroenterology department at the Trust since September 2017. The Trust was subject to an ongoing action plan as a result of the previous reviews. In particular, concerns were raised around supervision arrangements in and out of hours, management of outlier patients and the lack of consistent, consultant-led teaching programmes. It was noted that the General Medical Council National Training Survey (GMC NTS) results had deteriorated over the past two years.
Training programme / learner group reviewed	Gastroenterology
Number of learners and educators from each training programme	The review team met with nine foundation and core trainees and three specialty trainees at grades three to six (ST3-6). The review team also met with educational and clinical supervisors in gastroenterology, a senior gastroenterology nurse and the following Trust representatives: • Director of Medical Education • Head of Medical Education • Interim Medical Director • Interim Divisional Director, Specialist Medicine • Divisional Manager, Specialist Medicine • Guardian of Safe Working Hours • Clinical Director Gastroenterology • Educational Lead, Gastroenterology • Foundation Training Programme Directors.
Review summary and outcomes	The review team identified several areas of good practice, including the introduction of a cap on outlier patient numbers, the range of learning opportunities available to trainees and the good working relationships between the medical and nursing teams (please see Good Practice section below). One Immediate Mandatory Requirement was issued regarding the need for a robust process to manage the transfer of patients to other Trusts for interventional radiology treatment. The review team identified the following additional areas for improvement: • Safe handover of patients between the medical admissions unit and medical or outlier wards was identified as unstructured and often missing • The review team heard of cases where foundation year one (F1) trainees were not adequately supported when working at weekends due to a high workload and the lack of middle-grade cover • The departmental induction was described as informal and inconsistent. • Foundation and core trainees reported that they spent a significant amount of time doing administrative tasks which could be performed by non-medical staff, especially when the Doctors Assistant was on leave

	• The core trainee rota at Queen's Hospital did not include scheduled clinics as per curriculum requirement and trainees found it difficult to attend clinic due to workload on the ward • Higher trainees were not able to access sufficient numbers of endoscopy lists to meet their curricular requirements • Consultants rostered to work on the inpatient ward did not consistently ensure their schedules were free of clinics, endoscopy lists and other commitments • The Guardian of Safe Working Hours required substantial administrative support to manage and follow up on exception reports and ensure that data around exception reporting was escalated to the Trust Board • There was a single consultant responsible for educational supervision of all higher trainees (seven in total). This was a significant additional workload for this individual and created difficulties when this consultant was on leave • Not all clinical supervisors had supervision time included in their job plans • There was a new core trainee-led teaching programme initiated in December 2018, but this required consultant oversight and leadership to become a formal, curriculum mapped programme with appropriate feedback and attendance records. The review lead thanked the Trust for the improvements made so far. It was noted that there were further changes planned which had not been implemented yet, including assigning a doctors' room on the inpatient ward, increasing the number of computers available on the ward and recruiting a locally-employed doctor to improve middle-grade rota cover. The review lead stated that HEE would conduct a follow-up review in three to four months including all medical specialties and would continue to support the department and monitor progress in the interim period. The department was advised to submit the action plan to the Trust Executive and nominate a Board member to oversee education and training to ensure senior management support for the quality improvement process. The Trust was informed that HEE would continue to liaise with the GMC and NHS Improvement regarding the Trust's progress against the action plan.

Quality Review Team			
HEE Review Lead	Dr Sanjiv Ahluwalia Postgraduate Dean, North East London Health Education England (London and Kent, Surrey and Sussex)	**Deputy Postgraduate Dean**	Dr Indranil Chakravorty Deputy Postgraduate Dean, North East London Health Education England (London and Kent, Surrey and Sussex)
Head of Specialty School	Catherine Bryant Head of School of Medicine	**Foundation School Representative**	Keren Davies Director of North East Thames Foundation School
GMC Representative	Samara Morgan	**NHSI Representative**	Cathy Cale

	Principal Education Quality Assurance Programme Manager Visits and Monitoring Team General Medical Council		Deputy Medical Director National Health Service Improvement London Region
Lay Member	Kate Rivett Lay Representative	**HEE Representative**	Paul Smollen Deputy Head of Quality, Patient Safety & Commissioning Health Education England, London
HEE Representative	Louise Brooker Learning Environment Quality Coordinator Quality, Patient Safety & Commissioning Team Health Education England, London	**HEE Representative**	Andrea Dewhurst Quality, Patient Safety & Commissioning Manager Quality, Patient Safety & Commissioning Team Health Education England, London
Observer	Kenika Akinwumi Learning Environment Quality Coordinator Quality, Patient Safety & Commissioning Team Health Education England, London		

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

The review team thanked the Trust for accommodating the review and for the efforts made in facilitating the process.

The review team was informed by the Medical Education Team of the following improvements made since the previous review:

- In response to concerns about clinical supervision, the consultants allocated to the inpatient wards now carried mobile phones for the trainees to contact them when they were off the ward
- The department had introduced an additional middle-grade locally employed doctor (LED) post at Queen's Hospital to improve cover at higher trainee level and ensure that the trainees could be released for teaching without compromising patient care
- Weekly teaching sessions had been reinstated at Queen's Hospital
- The department held regular trainee focus groups on both Trust sites
- A Trust-wide rota improvement Board had been created which included trainee representatives, the Guardian of Safe Working Hours (GoSWH) and members of the postgraduate medical education team and met fortnightly to provide a 8-week forward review of rotas to avoid potential gaps and consider new safe and sustainable rota models. The Board aimed to have phase 1 (Foundation in Medicine) new rotas implemented for February 2019
- The number of gastroenterology outlier patients had been capped at four since 19 November 2018
- The department was reviewing the availability of endoscopy training lists for the higher trainees
- The Trust had made environmental improvements at the Queen's Hospital site including designating a junior doctors' office on the gastroenterology ward, planning to increase the number of computers and moving the patient board to allow more private discussion at board rounds.

The GoSWH stated that the gastroenterology department had the highest number of exception reports across the Trust and that all of these related to trainees working beyond their planned hours. The Trust used the e-roster system to monitor numbers of hours worked. The GoSWH advised that foundation and core trainees tend to submit a higher frequency of reports than higher trainees. The GoSWH did not routinely report to the Board and had difficulty in tracking fines and payments. The review team heard that a full-time administrator was required to support this work (please see Other Actions section). The GoSWH reported that trainees were usually paid overtime rates when their exception reports were signed off, as it was thought that giving time off in lieu was likely to adversely impact on already busy workloads. The consultants indicated that the recently implemented (since 19.11.18) outlier patient cap had reduced trainee workload and the GoSWH noted that exception report rates from the department had decreased from 14 in September to below 10 in November after the cap was introduced. The GoSWH also highlighted that the higher trainees were on both the gastroenterology rota and the acute medical on-call rota which made their hours and reporting patterns more difficult to track.

The Divisional Director for Specialist Medicine had left the Trust and an Interim Division Director (IDD) had been appointed the week prior to the review. The IDD reported that management of the gastroenterology department was going to be transferred to the surgical division and that this would help the department to work more closely with other interventional services. The IDD outlined the following issues which the division and department were working to address:

- There had been negative feedback about the professional interface between emergency medicine and general medicine at Queen's Hospital which the IDD planned to address at management level as well as with the relevant clinical staff
- The IDD planned to meet with trainees across the medical specialties to obtain feedback about training and practice, particularly good practice that could be replicated from one Trust area to another
- Consultant job plans were under review to include protected time on the inpatient wards for a formal board round from 15:00-16:00 on weekdays
- Trainee job plans were to be altered to include weekly protected time for supervised learning events including completion of e-portfolios.

The Postgraduate Dean thanked the postgraduate medical education team and the divisional group for the work done to improve the trainees' experience.

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** The review team was informed that gastroenterology outlier patients were admitted to a surgical ward and that the ward nurses alerted the gastroenterology team if outlier patients were not seen by mid-afternoon. The trainees reported that they called the outlier ward each day at handover to find out if new outlier patients had been admitted as there was no formal handover process for these patients. Handover was also inconsistent for patients referred from the medical admissions unit. Trainees described patients being brought to the ward with no handover or referral call. The supervisors stated that these patients should be reviewed by an on call medicine consultant or acute medical doctor prior to transfer, but that there was no process to ensure that this was done. The trainees advised that consultants did not see every patient every day but that patients were seen by the medical post-take team prior to admission on the surgical ward. Trainees were responsible for conducting independent daily rounds of stable inpatients. The trainees felt that this process was safe for patients and that the reduction in outlier numbers had reduced their workload. The review team heard that there were ongoing capacity gaps in the interventional radiology department which had led to delays in patients receiving treatment. In some cases, the trainees had arranged for patients to be transferred to other hospitals. The trainees reported that this constituted a patient safety risk as well as creating additional workload for the doctors in arranging patient transfers.	Yes, please see G1.1a Yes, please see G1.1b
G1.2	**Appropriate level of clinical supervision** The trainees reported that during the week there was good senior support available on the ward. At weekends the foundation year one (F1) trainees worked with a consultant. The review team heard that weekends were busy and F1s sometimes felt that the work was beyond their level of competence and confidence. There had been one instance where a consultant had not attended a weekend ward round and the trainee had not been aware of how to escalate this. However, during weekdays the trainees advised that there were good opportunities to learn new skills under supervision and there was always consultant supervision in clinics. The higher trainees participated in the acute medical on-call rota but there was no higher trainee allocated to work weekends in gastroenterology. The supervisors reported that trainees had reported difficulties in contacting consultants at times, so the department had introduced a (DECT) mobile phone which the ward consultant carried. The review team heard that consultant attendance on the wards in the afternoon was inconsistent as this was not a job planned activity for all consultants.	Yes, please see G1.2
G1.3	**Rotas** The gastroenterology inpatient ward had 30 beds and there were up to four outlier patients at any one time on the surgical ward. The junior trainees advised that there was a ward round each morning at around 09:00 which included multidisciplinary input	

	and a board round at 14:30. The trainees reported that consultants rarely attended the 14:30 round, that trainees were sometimes not aware when the consultant would return to the ward and that some did not attend the ward at all in the afternoon unless requested to review a particular patient. The F1s expressed frustration that they were not always able to completely attend full ward rounds due to the conflicting demands on their time and lack of prioritisation of tasks. The weekday junior doctor rota at Queen's Hospital included a minimum of four foundation and core medical trainees (CMTs) and one higher trainee. There were four higher trainees in the department, one of whom worked less than full-time. It was noted that on most weekdays there were two higher trainees on the rota to cover the ward and take calls and referrals. On days when three higher trainees were working, the third could attend clinics or endoscopy lists. However, the higher trainees advised that it was difficult to ensure this level of cover once annual leave, teaching and zero days were taken into consideration. The trainees were aware of the plan to recruit a locally-employed doctor (LED) to work weekdays on the ward but noted that this recruitment had not happened yet. It was anticipated that this would make workloads more manageable on days when only one higher trainee was working and increase the number of days when one trainee was free to seek learning opportunities. The junior trainees felt that they were able to give good continuity of care on the wards as they were typically rostered to work there for one or two-week periods. The higher trainees reported that at higher grades they were able to run the ward with support from the consultant. The wards were described as being busy, with a good range of pathologies for learning and a strong team working ethos. Referrals were received by email and phone and were taken by the trainee on-call. The review team heard that the volume of calls was not excessive and that on-calls were manageable if the trainees were not also trying to cover other areas. When asked what would improve workloads, the higher trainees advised that other hospitals included an additional 'twilight' shift for a higher trainee or LED to provide increased staffing during the busiest period of the day. The trainees had made this suggestion at local faculty group (LFG) meetings but were aware that it would not be possible to increase the number of shifts on the rota unless additional doctors were recruited.	Yes, please see G1.3
G1.4	**Induction** The trainees described variable experiences of induction. F1 trainees had a week of shadowing when they started in post and reported finding this very helpful. The CMTs and higher trainees stated that their departmental induction had been brief and informal. Some trainees had been rostered to work nights during their first week and had received written information in place of a departmental induction.	Yes, please see G1.4
G1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team was informed that there had been a fire in the Queen's Hospital endoscopy unit in early 2018, which had reduced the unit capacity and the number of lists available for training. One endoscopy room had been closed for repairs since the fire, but the endoscopy nurse reported that it was due to reopen in January 2019. Additionally, a group of nurses had recently completed their endoscopy training, which had reduced the demand for training lists. The nurse advised that there were separate training lists allocated to medical and surgical trainees. The higher trainees reported that they typically attended one endoscopy list per week but needed two lists per week to meet their curricular requirements.	Yes, please see G1.5a

	The CMTs at Queen's Hospital advised that there was no clinic time included in their rota and that there was little support from consultants for them to leave the ward to attend clinics. The review team heard that in the afternoons it was difficult for CMTs to arrange to leave the ward for clinic due to the lack of consistent consultant presence and concern about leaving the F1s to cover the full junior trainee workload. The CMTs felt that there was no distinction between their roles and the F1s' roles, leading to concerns that they were not well-prepared for specialty training and participation in the acute medical on-call rota. The higher trainees reported that the junior training experience at King George Hospital included more opportunities to attend clinics and outpatients as staffing levels were better than at Queen's Hospital.	Yes, please see G1.5b
G1.6	**Protected time for learning and organised educational sessions** The junior trainees reported that there was a weekly, trainee-led teaching session which had previously focused on specific patient cases but had recently been formalised and was now based on a series of pre-planned topics. The trainees were responsible for preparing the teaching material and, although a consultant usually attended, the trainees did not feel that the consultants were involved or interested enough in the teaching programme. There was also monthly foundation teaching, but this was described as variable in quality. Foundation trainees advised that when they attended these sessions it increased their colleagues' workloads and that they needed to return to the ward after teaching and work late to mitigate this. All trainees stated that they were able to attend regional study days.	Yes, please see G1.6

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	**Impact of service design on learners** The review team asked the trainees about recent changes made within the department. The junior trainees reported that the ward environment at Queen's Hospital remained difficult to work in as there was no doctors' office as yet, so trainees continued to share the nurses' station. The trainees indicated that a broken computer had been replaced, a new computer had been put on the ward and there were plans to buy a computer on wheels for use during ward rounds. The high rate of exception reports was discussed. The junior trainees reported that they often stayed late due to workloads but that there were processes and systems	

	which could be improved to make their work more efficient. For example, the junior trainees booked their own clinic appointments, followed up with patients who did not attend clinic, transcribed prescriptions and made referrals and requested investigations using paper forms. There was a doctors' assistant who worked on the inpatient ward at Queen's Hospital on weekdays and was described as a valued colleague who undertook many of these administrative tasks. The complexity of some patient cases was also given as a reason for staying late. This affected both junior and higher trainees, although the junior trainees were aware that some aspects of care took them more time due to inexperience and most trainees did not think it was appropriate to exception report if they stayed late to care for an unwell patient. The review team heard that it was common for junior trainees to work later on a Friday evening as preparing the weekend handover was time-consuming. The service design at King George Hospital was described as more conducive to efficient working, with more computers on the ward, a dedicated doctors' office and secretarial support to book clinics. The supervisors informed the review team that there had been difficulties in moving from a five to a seven-day consultant rota as there were not enough staff to cover this. The supervisors believed that this had impacted negatively on the time available for training and compromised consultant morale and engagement. This change had occurred in 2016 and since then the consultants and managers had undergone mediation. The review team heard that morale was improving and that the consultants were working to address the impact on the trainees.	
G2.2	**Appropriate system for raising concerns about education and training within the organisation** There were monthly departmental meetings which were attended by trainee representatives. The trainees advised that the department acted on the feedback given at these meetings and that they were informed of the actions taken.	
G2.3	**Organisation to ensure access to a named educational supervisor** The higher trainees advised that they were assigned educational supervisors (ESs) for gastroenterology when their rotations started and that they had separate ESs for their general medicine training.	

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.

	N/A	

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 ESs reported that their job plans included 0.25PA (programmed activities) for each trainee they supervised. At the time of the review there was one ES responsible for all 7 of the higher trainees at Queen's Hospital. The review team heard that not all consultants had time for clinical supervisor (CS) activities included in their job plans.	Yes, please see G4.1a Yes, please see G4.1b

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 higher trainees reported that they had good opportunities to carry out audits and quality improvement projects. The trainees were also aware of opportunities provided through the HEE Leadership Academy. The junior trainees indicated that they were able to complete assessments and supervised learning events (SLEs) but that it was more difficult to get some consultants to complete these than others.	Yes, please see G5.1a Yes, please see G5.1b
G5.2	**Opportunities for interprofessional multidisciplinary working** The review team heard that there were good working relationships between the medical and nursing teams and that the endoscopy nurses were very accommodating towards trainees.	

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.

	N/A	

Good Practice and Requirements

Good Practice
The Doctors Assistant working on the inpatient ward was described by the trainees as a valued colleague who undertook many of the administrative tasks that normally fell on the junior trainees.
The department had imposed a cap on outlier patient numbers (maximum of four) and this had had a significant positive impact on trainee workloads.
The higher trainees reported that they had access to a good range of learning opportunities via exposure to wide case-mix.
All trainees described good working relationships between the medical and nursing teams in the department.
Training at King George Hospital was commended for the range of training opportunities available, good support from colleagues and a well-run teaching programme.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
G1.1b	Patients who require interventional radiology services who are being seen by gastroenterology trainees are waiting an unduly long period of time for treatment or transfer to a neighbouring Trust and there is a lack of robust process for ensuring timely and regular treatment of patients.	Trust to ensure that an escalation plan with clearly delineated time-lines and responsibility is set up and agreed for all patients requiring interventional radiology services. This plan should be made available on the trust internal guidance and disseminated to all staff.	R1.2

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
G1.1a	The department to initiate a daily formal (auditable) handover of all patients transferred to medical/ outlier wards from ED/ MAU requiring a clinical review out-of-hours, including at weekends.	Please provide confirmation from Divisional Director (regular audits) that these daily handovers are functioning and fit for purpose.	R1.14
G1.2	The department to ensure appropriate level of clinical supervision at the weekend is maintained at all times. The department will	Please provide details of trainee timetables which should clearly indicate named clinical	R1.8

	demonstrate that each trainee within the department is familiar with standard operating procedures for escalating concerns	supervisor at all times, including contact numbers.	
G1.3	The consultants assigned to cover the inpatient wards should conduct daily scheduled ward rounds for all patients under the care of the department (including outliers) and an afternoon board round at a fixed time each weekday, which will include a review of new admissions and unwell or unstable patients.	Please provide confirmation from Divisional Director/ GM of Consultant rota and allocated time in job plans. Please provide copies of trainee feedback via LFG confirming that these rounds are carried out by the end of February 2019.	R1.8
G1.4	The department should ensure that each trainee receives a formal, structured departmental induction prior to starting their rotation.	Please provide copies of the induction programme and feedback obtained for the next cohorts of foundation trainees and CMTs. Please provide initial update by end of February 2019.	R1.13
G1.5a	The department will demonstrate that higher trainees at both Trust sites have access to sufficient training endoscopy lists to meet curricular requirements (JAG accreditation). If this is not possible, an early alternative training plan should be discussed, agreed with the Training Programme Director (TPD) and facilitated including arrangements with neighbouring trusts.	Please provide copies of the February 2019 higher trainee rota including endoscopy lists (approximately 2/week) and feedback from the trainee focus group in March 2019 confirming that trainees are able to attend the scheduled sessions.	R1.19
G1.5b	The department will demonstrate that all core trainees are rostered to attend one clinic per week as required by the curriculum and that this time is included in the trainees' job plans.	Please provide copies of the February 2019 CMT rota and trainee job plans showing that weekly relevant clinic sessions are included. Please provide initial update by end of February 2019.	R1.12
G1.6	The department will continue to run weekly teaching sessions lasting one to two hours for each group of trainees (foundation, CMT, higher). The content of these sessions should be mapped to the relevant curriculum and there should be a consultant responsible for each session. These sessions should offer opportunities for trainees to present to their peers and receive feedback.	Please provide curriculum mapping of topics, trainee feedback and attendance registers for the teaching sessions at the end of February 2019.	R1.16
G4.1a	The department will ensure that each ES is allocated a maximum of two trainees and confirm that 0.25 PA per trainee is available in each ES's job plan for supervision and mentorship activity to occur at regular intervals.	Please provide copies of the job plans for all ESs by the end of February 2019.	R4.2
G4.1b	The department will confirm that all consultants have a minimum of 0.25-0.5PA in their job plans for education and training. There should be a regular educator appraisal cycle for CSs led by the DME, TPD or educational lead to assess compliance with the GMC training standards.	Please provide a log of educational activity such as teaching endoscopy lists, clinics, teaching ward rounds or other activities evidenced by way of spreadsheet returns to the PGME team. Please also provide records showing CS appraisal dates and outcomes by end of March 2019.	R4.2

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
G5.1a	The department should continue to demonstrate support for all core and higher trainees to undertake appropriate leadership activity as per the London Leadership Academy and HEE Leadership spiral toolkit relevant to their level of training.	The department should work with the London Leadership Academy to identify appropriate activities and provide support to the trainees to undertake these based on the curriculum and Spiral Leadership Toolkit.	R1.22
G5.1b	The department should demonstrate that all trainees are facilitated to undertake at least one QI project during their rotation. Appropriate training in QI methodology, resources and supervision should be provided.	The Trust is advised to nominate a dedicated QI Lead to develop and run the QI training.	R1.22

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The Trust should consider creating an administrative support role to assist the GoSWH in collating exception reporting data for the Trust Board and liaising with the medical workforce team to track fines and payments.	Trust
The department should continue to hold regular LFG meetings (minimum four per year) which are minuted and include discussion of trainee feedback, exception reports, rota issues, culture, education and training matters. An attendance register and minutes should be available to review.	Trust

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Sanjiv Ahluwalia
Date:	31/01/2019

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.