QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Guy's and St Thomas' NHS Foundation Trust

Renal Medicine, Medical Oncology, Core Medical Training and Foundation Medicine

Risk-based Review (focus group)

Quality Review report

11 December 2018

Final Report

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Quality Review details

Background to review	Health Education England (HEE) felt that with the release of the 2018 General Medical Council's (GMC) National Training Survey (NTS) results and an Educational Leads Conversation (ELC) which took place in October 2018, that a conversation with the trainees in Medicine was required.
Training programme / learner group reviewed	The review team met with a number of trainees from each of the four training groups, as detailed below; • Foundation Medicine – Five F1-F2 oncology trainees and three F1-F3 renal trainees. • Core Medical Training – CMTs from oncology and renal • Medical Oncology– higher trainees as well as clinical oncology trainees, who attended as they work on the same rota/working pattern • Renal – higher trainees
Quality review summary	The 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: • The review team were pleased to hear of the high standard of clinical care for renal patients expressed by all grades. • The review team heard from the trainees that the consultants in the oncology department were both approachable and supportive. • The review team were pleased to hear that the higher renal trainees were released to attend their regional training sessions. • The review team were pleased to hear that a Physician Associate had been introduced and that the feedback from all trainees was positive. • The review team were pleased to find that there were no red flag indicators for foundation trainees in regards to prescribing or administration of cytotoxic drugs. • The review team were pleased to hear that the core medical training trainees had good clinic accessibility and all felt that the clinic experience provided was a positive one. • The review team were pleased to hear that all of the foundation trainees had access to appropriate clinical supervision both day and night. However, the review team also noted a number of areas for improvement: • The review team felt that the environment on the renal transplant ward needed addressing, specifically with regard to clarification and then appropriate communication of tasks, roles and responsibilities of junior medical staff relating to the care of patients undergoing surgical procedures. • The review team were concerned to hear that junior doctors felt unsupported by the nursing staff on the nephrology ward and in particular asked that the Trust review the processes involved in end of life and palliative care pathways.

	• The review team request that the Trust review the handover processes in place to provide a more robust and educational environment for trainees in both renal medicine and oncology. • The review team were concerned to hear that the weekly one-hour teaching sessions for core medical training trainees in renal medicine were not bleep free and ask the Trust to ensure that these sessions bleep free. • The review team recommended that the Trust review trainee clinic loads to allow oncology trainees to attend regional teaching sessions on time. • The review team were concerned that there were excessive administrative and repetitive tasks for all trainees in oncology, such as cross cover of inpatient and outpatients from multiple clinics that they did not participate in, interrupting their clinical and training time, and making decisions about patients that the trainee was not familiar with. • The review team felt that clear lines of responsibility and escalation of patient care were required when oncology trainees were working off site. • The review team felt that both the renal and oncology services would benefit from a comprehensive review of workforce including targeted introduction of non-medical roles to support clinical and administrative activity, such as medical transcription.

Quality Review Team			
HEE Review Lead	Jo Szram, Deputy Postgraduate Dean, Health Education England (London and the South East)	**Lay Representative**	Jane Chapman, Lay Representative
Training Programme Director	Shelley Srivastava, Core Medical Training Programme Director (North West London) Health Education England	**HEE Representative**	Ed Praeger, Deputy Quality, Patient Safety and Commissioning Manager, Quality, Patient Safety and Commissioning Team, Heath Education England (London and the South East)
Foundation Representative	Jan Welch, Head of School of Foundation, South Thames Foundation School, Health Education England	**Observer**	Susan Ptak, Quality, Patient Safety and Commissioning Administrator, Quality, Patient Safety and Commissioning Team, Heath Education England (London and the South East)

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
Med 1.1	**Patient safety** The review team were pleased to note that the foundation and higher renal trainees informed the review team that if faced with a patient safety issue, the trainees would know who to contact within the Trust to report it. When asked if the trainees had witnessed or were concerned about areas that could potentially impact patient safety, the foundation trainees indicated that, due to each patient on the wards having a different consultant in charge of their care, the trainees felt that there was a potential patient safety risk through the lack of continuity of care. The foundation trainees indicated that with the large number of tumour group teams in oncology the nurses were often unsure as to who to escalate to. The Core Medical Training (CMT) trainees indicated that the lack of consistent presence from a palliative care doctor on Patience Ward and apparent difficulties in communication between the ward nurses and palliative care nurses could have a detrimental effect on the patient experience and potential patient safety issues. The CMT trainees highlighted to the review team that they had started to directly contact and involve the palliative care team but felt that, due to the lack of formal arrangements, this mechanism could potentially be missed by the next cohort of trainees. All trainees felt particularly unsupported by the nursing staff on the nephrology ward; this was in part they felt due to the relatively junior cohort of nurses staffing the ward. The CMT trainees on oncology reported concerns around handover, senior cover and outlying patients that had the potential to impact on patient safety. The medical oncology trainees informed the review team that a combination of a small weekend workforce and workload could lead to potential patient safety concerns.	Yes, please see Med1.1 below
Med 1.2	**Appropriate level of clinical supervision** When asked about the levels of clinical supervision that the trainees received, the foundation trainees indicated to the review team that they were often unsure of which patients were under the supervision of which consultant. The foundation trainees also indicated that with patients on the wards being cared for by a number of different consultants, the consultants would tend to arrive on the ward at different times, making it hard for the junior trainees to plan and organise their workload. With this in mind, the foundation trainees described a situation where they had received different instructions from the middle grade trainees compared with the plan made by the consultants; at times they have had to wait until the consultant ward round to clarify the situation. As	Yes, please see Med 1.2

	consultants started ward rounds after clinics, the foundation trainees indicated that these were often delayed and they were unsure of the start time, on a daily basis. The foundation trainees explained to the review team that with the consultants often busy in clinic, the middle grade (F2 and CMT) trainees would often have to run the ward with help from the foundation trainees. The foundation trainees highlighted that the higher trainees were always accessible and that there was a good structure in regard to the higher trainees on the wards. When patients were admitted over the weekend, the foundation trainees explained that a middle grade trainee would initially see the patient before discussing the case with a higher-grade trainee. The foundation trainees confirmed to the review team that there were higher grade trainees on call and accessible to the trainees overnight. The foundation trainees explained to the review team that they felt nursing care standards varied. When asked about the levels of clinical supervision they received, the CMT trainees indicated that there was no structure and no cohesion within the department. The CMT trainees indicated that although the consultants were helpful, they were often difficult to contact. The higher oncology and renal trainees both indicated to the review team that if they needed to contact a consultant, that although it could take a moment to find them, that there was never a problem in contacting them in a timely manner.	
Med 1.3	**Responsibilities for patient care appropriate for stage of education and training** When asked whether the trainees were undertaking inappropriate duties, the foundation trainees highlighted to the review team that they would often spend a large amount of time taking bloods from patients. The foundation trainees highlighted to the review team that there was a massive skill set divide between different nursing staff with a foundation trainee explaining that they had had to perform all of the cannulas due to the number of junior nurses. When asked, the foundation trainees all confirmed that they had not undertaken any procedures that they were uncomfortable with and had not prescribed any cytotoxic drugs. The foundation and core medical trainees highlighted to the review team that due to the surgical team not having any junior trainees within its department, the foundation trainees felt that they were being used as junior surgical trainees whilst on the renal transplant ward. The foundation trainees highlighted to the review team that they had spoken to their consultants regarding this, and that this message had been passed on to the surgical teams with the agreement made that surgical middle grade trainees were told to specifically pick up all jobs for the surgical patients. The foundation trainees felt that it was improving, but that it often still required prompting.	Yes, please see Med1.3 below
Med 1.4	**Rotas** When asked about the workload and intensity of the role, the foundation trainees explained to the review team that the intensity of the work was appropriate but that the trainees would often stay past their rostered hours due to the lack of organisation of the work days. The foundation trainees indicated that they often spent a lot of time waiting around for consultants. When asked if this had been fed back to the consultants, the foundation trainees indicated that it had, but felt that the consultants did not always see the problems on the ground as much as the trainees and may not fully appreciate the problem. The foundation trainees explained that due to the structuring of the day, there would be episodes where a middle grade trainee would review a patient, only for that patient to then be reviewed again by a higher trainee later in the day.	

	The foundation trainees highlighted to the review team that the middle grade trainees were now making sure that foundation trainees were sure of which team they were working on for that week. The foundation trainees also highlighted that being rostered on to the transplant ward was of limited educational value as the trainees was unable to prescribe a large proportion of the drugs to the patients and therefore also could not complete discharge prescriptions. When asked about the rota and the structure within the department, the higher oncology trainees highlighted that there had been an improvement since previously working in the department and that this was mainly due to not doing resident nights anymore. The higher oncology trainees highlighted that they were still rostered to be available over the phone and would come in if needed. The higher medical oncology trainees indicated to the review team that with a limited number of trainees in the department, getting annual leave could be challenging. The higher medical oncology trainees also highlighted that post nights there was a lot of cross covering, which could also become difficult for the trainees. The higher medical oncology trainees explained to the review team that this had been raised with the department but there was no definite plan as yet. When asked, the clinical oncology higher trainees explained to the review team that on Thursdays they were a little thin on the ground, with trainees carrying up to eight bleeps at a time. The clinical oncology trainees also highlighted to the review team that the consultants would carry out their ward rounds on Mondays and Tuesdays and did not feel that this was beneficial with the trainees being there. The higher oncology trainees explained to the review team that with trainees also working at the Queen Elizabeth (Woolwich) site once a week, the trainees were often off site which increased the need to cross cover. They also received a lot of zero days' built into their rotas. The trainees highlighted the disruption that these requirements caused. The higher oncology trainees highlighted to the review team that they had had to act down on a number of occasions but felt that with more trainees available, especially medical oncology trainees, this would improve. The higher oncology trainees highlighted that they currently work a one in four weekend rota which was felt to be intense in terms of work-life balance. When asked if either the renal or oncology higher trainees were exception reporting, a number of the higher oncology trainees indicated that they did not know how to exception report whilst the rest indicated that they knew how to but never had. The higher renal trainees all indicated that they knew how to exception report and that the department had been responsive to feedback received from last year's cohort. When asked if the trainees would recommend this post to another colleague, a number of the higher oncology trainees indicated that although the work within the department was good for training, the rota would be the main reason why they would not recommend the post.	Yes, please see Med 1.4
Med 1.5	**Induction** When asked if the trainees had received an induction, the foundation trainees all indicated that they had received a department induction as well as a Trust induction. The foundation trainees praised the oncology induction. The foundation trainees highlighted that starting on call straight after the induction meant that a number of trainees did not have their computer login yet. The trainees confirmed that they had not been sent any information or log ins prior to the induction. The higher oncology trainees explained that the induction which covered the Trust's multiple computer systems was beneficial. The higher renal trainees indicated to the review team that it would have be beneficial to have been shown more specific procedures in terms of administration and induction	Yes, please see Med 1.5

	before starting on weekends or nights and felt that the induction could be more structured.	
Med 1.6	**Handover** When asked about the handover arrangements, the CMT trainees felt that the system in place wasn't good, with each handover being run by a higher-grade trainee of which the middle grade trainee would often just hand over general information that the higher-grade trainee did not know. The CMT trainees indicated that this led to them often sitting and not saying anything rather than being able to start on tasks, or not attend at all The CMT trainees also felt that the handovers were too detailed and thus would often run over time by up to an hour. The general feeling from the CMT trainees was that handover was not a good educational opportunity. The CMT trainees also highlighted that when patients came in overnight, trainees would often not know which team they were admitted under. The CMT trainees indicated that there was now a dedicated post take ward round to try to address this but that this was new, and it was too soon to tell if it would resolve this issue. The higher renal trainees indicated to the review team that the handover was comprehensive and structured. They felt that there was no benefit to having two handovers on a Monday morning. The trainees explained that there was a night shift higher trainee to day time trainee handover at 8:15am followed by a consultant led handover at 9:15. The higher renal trainees felt that this often meant that they were repeating themselves. The higher renal trainees highlighted that the Friday afternoon handover before the weekend was very useful and effective.	Yes, please see Med 1.6 below
Med 1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** When asked if they would recommend this post to other colleagues, a number of foundation trainees informed the review team that due to the lack of structure in the oncology department, there were missed educational and learning opportunities. The foundation trainees also felt that the department was unsupportive and that there was a huge amount of responsibility being placed on foundation year two trainees. When asked about feedback that the consultant provided on clinical work the higher oncology trainees indicated that clinics were often too busy for consultants to observe the trainees or review patients with them, and that there was not a formal system in place for discussions to take place between the trainee and the consultant after the clinic. When asked, the higher oncology trainees indicated to the review team that although the post was service heavy, there were training opportunities available and that minor restructuring of the days would help progress these opportunities. The higher renal trainees expressed their disappointment in the educational benefits of the post, citing the rota, experience, level of teaching and lack of opportunities as factors against recommending the post. The higher renal trainees explained to the review team that they did not feel that the rota was well balanced, particularly an imbalance between on call/ward work and procedures. The higher renal trainees also highlighted to the review team that there were only two consultants available to sign them off for line insertion, with a number of trainees therefore finding it difficult to get signed off. Although they were now rostered on to the procedures week, this was sometimes several weeks after starting in post. Although the higher renal trainees highlighted the positives of the procedures week and renal assessment unit, the trainees also stated that that they did not feel fully ready when starting within the department and thought that more experience when they started would lend to a better learning experience at the Trust. More practical skills were highlighted by the trainees as one of the ways for the department to improve on their feeling ready for the job.	Yes, please see Med 1.7 below

Med 1.8	**Protected time for learning and organised educational sessions** When asked about the teaching programme within the department, the foundation trainees explained to the review team that they received weekly teaching on a Wednesday before the handover but felt that it could be longer. The session was scheduled for 45 minutes but the trainees often felt that it was closer to 15 minutes of actual teaching time. When asked about CMT teaching sessions, the CMT trainees explained that they would often join the teaching sessions by video link and that the teaching session would last approximately an hour. The CMT trainees highlighted that they would have to carry their bleep on them during these teaching sessions and that they would often be bleeped multiple times throughout the teaching session. The CMT trainees explained that there were not enough staff in the department to hand the bleeps off to during these sessions. The review team informed the CMT trainees that they should be receiving the teaching bleep free. The trainees highlighted the two new locum doctors and Physician's Associate (PA) that had all recently started in the department but indicated that the trainees would move the bleeps around between themselves to try and cover the sessions. When asked about regional teaching, the oncology CMT trainees indicated that they had been able to attend and the renal CMT trainees highlighted that they had not had any regional teaching sessions yet. The renal CMT trainees highlighted that they had two full weeks of renal clinic as well as generic medical clinics of which they had found very useful. The higher oncology trainees explained to the review team that the regional teaching sessions were always held in the afternoon, following on from a morning clinic. The trainees explained that this morning clinic very rarely finished on time so that meant that trainees were often late to the regional teaching session. The trainees also explained that the consultants would rarely allow for trainees to leave the clinic early. The higher oncology trainees informed the review team that the more junior trainees that had been advised by the Trust TPD to attend the MSc course, were now attending the distance learning Newcastle course instead of the ICR course. The higher renal trainees all indicated to the review team that they were able to attend the regional teaching courses and that these were scheduled into their rota.	Yes, please see Med1.8a below Yes, please see Med1.8b below

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.

Med 2.1	**Impact of service design on learners**	

	When asked about the service design of the oncology department, the CMT trainees indicated that the inpatient numbers were manageable but the lack of systems in place made the workload harder than it needed to be. The CMT trainees indicated that they would have to escalate to six different teams. The CMT renal trainees indicated that in the post, trainees were expected to do a lot of the surgical tasks and that this was taking the trainees away from the medical training that they required. The CMT trainees also indicated that they spent a lot of time doing jobs that were below their level of training. The CMT trainees explained to the review team that learning opportunities overnight were limited and that during daytime ward work, trainees were spending a lot of time completing administrative duties. The CMT renal trainees indicated to the review team that 80% of the patients were surgical admissions and should be seen by the surgical team. Due to the surgical team not having any junior trainees, the CMT trainees felt that this work often came back on them. When asked if the pharmacists could help out with the drug charts, the CMT trainees explained that many of the pharmacists were non-prescribing pharmacists and so could not support them in this way. When asked about inpatient and outpatient work, the higher oncology trainees explained to the review team that they would conduct three outpatient clinics a week, typically two half days and one full day. The trainees explained that they received a couple of days to complete the administrative work done from the clinics but that this was during their ward cover time so they were often disturbed. Some morning clinics routinely overran into the afternoon. The higher oncology trainees explained that when cross covering, each trainee could be in charge of anything from 5-25 patients. The difficulty of this cover was added to when only working with some patients for a single day leading to a lack of continuity. When asked if they were working in the recommended number of clinics to complete their curriculum, the higher oncology trainees indicated that ward duties as well as bleeps would often prevent them from attending learning opportunities. The trainees indicated that all bleeps for the consultants' inpatients and outpatients would come through to them, and although many would be addressed by other people in the department, they found this situation overwhelming. The trainees also indicated that a constant series of bleeps could become upsetting for the patients that the trainee was seeing, such as when discussing difficult news. The higher oncology trainees indicated to the review team that they felt that the medical oncology weekend shift was too intense for a single person. The trainees indicated that a junior trainee was also required to see the 33-35 patients they were looking after at this time. The trainees recognised that a PA had recently started in post but highlighted that the PA did not work weekends. The review team recognised and commended the department for the introduction of the PA but feels the department would further benefit from review of its workforce, including targeted introduction of non-medical roles to support the clinical and administrative activities. When asked about being able to attend the regional teaching days, the oncology trainees highlighted that the clinics before the regional teaching sessions would almost always overrun, making it difficult to attend the teaching sessions on time. The higher renal trainees explained that when covering overnight, a lot of the work that was covered was medical cover. The higher renal trainees explained that the department was introducing a face to face team meeting with the Intensive Treatment Unit (ITU) at 11pm to improve clinical cover across the hospital at night.	Yes, please see Med2.1a below Yes, please see Med2.1b below
Med 2.2	**Appropriate system for raising concerns about education and training within the organisation** When asked if there was a trainee representative for the foundation trainees, the trainees indicated that the department had asked for a nomination toward the end of	Yes, please see Med 2.2

	the last rotation and then again on the day of the first local faculty group (LFG) meeting. The foundation trainees indicated to the review team that there was informal feedback from this LFG to the trainees. The higher renal trainees indicated that they had a representative and that this representative had met with the Training Programme Director to discuss issues highlighted in the department. There was no system for oncology that the trainees were aware of.	
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.**		
Med 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** When asked if any of the trainees had witnessed or been subject to bullying or undermining behaviour, the foundation trainees indicated that they often felt that the surgical consultants would undermine them in front of other staff when they had not completed ward tasks or assessments, normally the reason why these weren't completed was that the trainees were unaware of management plans for surgical patients. The foundation trainees explained that they had spoken to the medical consultants and that they had been told that this would be fed back to the surgical consultants. The outcome from this feedback was not been formally fed back to the trainees. The CMT trainees echoed the foundation trainee's sentiments that the surgical consultants would treat the CMT trainees as surgical trainees and spoke to the trainees in a derogatory way when tasks had not been completed that the trainee did not know about. The trainees indicated that this undermining tone was used in front of other trainees as well as patients. The CMT trainees had not received formal feedback, but had heard through the 'grapevine' that the consultants had spoken about this. The higher renal trainees explained that they had witnessed an episode of a consultant being patronising to other members of staff but felt that this was more due to the consultant's personality than anything else. The trainee indicated that they would be happy to speak to their educational supervisor in the future about any similar issues.	Yes, please see Med 3.1
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.**		
	N/A	
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.**		
Med 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The higher renal trainees explained to the review team that they had received two procedure days although both of these days were transplant days so it had some potential to negatively impact overall training.	
Med 5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** When asked if the foundation trainees were able to get all of the practical experience that they required, the foundation trainees explained that although they were often competing for practical experience with the middle grade trainees, however, it was noted that they were also managing to gain enough experience for the post.	
Med 5.3	**Regular, useful meetings with clinical and educational supervisors** The CMT trainees and the higher renal trainees both indicated that they had met with their educational supervisors when asked.	
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 review team were pleased to hear of the high standard of clinical care for renal patients expressed by all grades.
The review team heard from the trainees that the consultants in the oncology department were both approachable and supportive.
The review team were pleased to hear that the higher renal trainees were released to attend their regional training sessions.
The review team were pleased to hear that a Physician Associate had been introduced and that the feedback from all trainees was positive.
The review team were pleased to find that there were no red flag indicators for foundation trainees in regards to prescribing or administration of cytotoxic drugs.
The review team were pleased to hear that the core medical training trainees had good clinic accessibility and all felt that the clinic experience provided was a positive one.
The review team were pleased to hear that all of the foundation trainees had access to appropriate clinical supervision both day and night.

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.**
Med1.1	The Trust is to review the processes around end of life care and palliative care pathways on the nephrology ward.	The Trust is to provide trainee feedback documenting improvements in implementation of end of life and palliative care pathways on the nephrology ward over a three month period.	
Med 1.2	The Trust is to review the current system of named consultant on the oncology wards and communicate this clearly to the junior staff. When a consultant is away or not available the juniors should be made aware of the consultant cover arrangements.	The Trust is to provide evidence of system for assigning consultants to admitted patients and the communication of this to trainees. Please provide an update within one month.	
Med1.3	The Trust is to communicate the roles and responsibilities of junior staff to all staff members on the renal transplant ward.	The Trust is to create and distribute the roles and responsibilities of the junior doctors to all staff members so that a clear understanding is held by all. Please provide evidence of the distribution of this information within three months and ensure that it has been agreed by all team members, with evidence of positive feedback from trainees via an internal forum.	
Med 1.5	The Trust is to ensure that IT log ins are provided for junior staff rostered to be on call immediately after induction	The Trust is to provide evidence that junior staff have IT log ins available to them for their on call shifts following induction. Please provide an update within one month.	

Med1.6	The Trust should look at the educational value of the handover currently in place and look at future ways to improve this with trainee input.	The Trust, through trainee feedback such as internal forums, are to look into ways to improve the educational value of handovers for both the renal and oncology trainees, which may include allowing trainees to leave the meeting if it overruns and handover is not relevant to their patients and delays their work tasks. This should be submitted within three months with evidence of positive feedback from a first trial or pilot.	
Med 1.7	The Trust to ensure that renal higher trainees receive prompt assessment and training for line access at the start of their rotation.	The Trust is to establish a system for ensuring all rotating higher renal trainees are assessed for line competency and receive appropriate training with potential for sign off in the first six weeks of their post, and submit evidence that this has been planned prospectively for the next rotation as well as evidence that all current trainees have been signed off within three months.	
Med1.8 a	The Trust to ensure that CMT teaching sessions are bleep free.	The Trust is to ensure that all CMT teaching is bleep free within three months. Trainee feedback documenting this will be required as evidence.	
Med1.8 b	The Trust is to ensure that trainees are able to attend their regional teaching sessions on time through the management of trainees clinics.	The Trust is to provide trainee feedback documenting that regional teaching was attended on time. Please provide an update within three months.	
Med2.1 a	The Trust is to review current working practices in oncology for patients who the trainee is not directly responsible for (e.g. clinic patients seen by other team members) as well as those of other teams when holding the bleep for inpatient cover due to leave, teaching, off site clinics and zero days.	The Trust is to review current working practices in oncology and provide a clearly documented procedure for reducing bleeps for administrative queries and results for example using members of the administrative team such as consultant secretaries and service administrators.	
Med2.1 b	The Trust is to look into further areas within the department that would benefit from non-medical roles, including administration, prescribing and increased support for phlebotomy. Current roles within nursing, ACPs and/or PAs to be explored to reduce high frequency non-urgent cannulation that is reported to be occurring on specific wards as well as other routine tasks.	The Trust is to provide an employment plan for non-medical roles within the department to support the workload within both renal and oncology services for both inpatient and outpatient activity. This should be submitted within three months and show planning over the next twelve months.	
Med 3.1	The Trust is to look into the reported undermining and culture within the renal team and ensure that trainees are aware that these issues have been addressed.	The Trust is to provide evidence that these discussions have taken place and that trainees are confident that they have been addressed and that mechanisms are in place for raising concerns in future. Please provide an update within one month.	

Recommendations

Rec. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
Med 1.4	Guardian of Safe Working to be informed of lack of knowledge of exception reporting mechanism at the Trust in the trainee groups	Evidence that Guardian has been made aware of this issue and details of actions taken by Guardian to address the issue.	
Med 2.2	The team recommend a more robust system of trainee representation and attendance at LFGs for each learner group with clear communication of mechanisms to submit issues and queries to the representative as well as a "you said, we did" feedback loop.	Evidence of nominated trainee reps for each learner group and inclusion into LFG invitation and attendance (with deputising when not available) and minuted trainee report.	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
N/A	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Jo Szram
Date:	26/02/2019

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.