Health Education England

North East London NHS Foundation Trust

Mental Health

Multi-professional Review (on-site visit)

Quality Review report

18 July 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Area for review	Mental Health
Number of learners met with	The review team met with postgraduate medical trainees in psychiatry and student learners across nursing and occupational therapy.
Number of educators met with	The review team met with a range of learners, clinical and education supervisors and educators from psychiatry, nursing and occupational therapy and the following Trust representatives: • Director of Nursing / Head of Therapies, • Director of Medical Education • Guardian of Safe Working Hours • Education Leads • Matron • College Tutor • Simulation Lead • Medical Education Manager

Background to review	The Postgraduate Dean for HEE London (north central and east London) had been contacted in February 2019 by colleagues who had concerns about the experience of junior doctors in the inpatient unit at Goodmayes Hospital (North East London Foundation Trust) and who were concerned that this reflected the experience of patients and their safety. The Postgraduate Dean contacted the Medical Director to discuss initially and as a result an action plan was developed by the Trust to address the concerns. Whilst the Trust has been engaging and providing action plan updates, the multi-professional review on 18 July was to assess progress against the action plan. In the interim period, the Care Quality Commission (CQC) undertook a well-led visit and provided the Postgraduate Dean with some initial feedback on the junior doctor concerns. There were also concerns raised through the Patient Safety Bullying and Undermining section of the General Medical Council (GMC) National Trainee Survey (NTS) that required investigation. HEE had previously undertaken one quality review to psychiatry at North East London NHS Foundation Trust: • Trust-wide review on 17 March 2015 This quality review resulted in two immediate mandatory requirements being issued to the Trust: • There were concerns about the management of the inpatient environment relating to physical healthcare on the Goodmayes Hospital site. The visit team required the Trust to conduct an urgent review of the inpatient environment and provide documentation for compliance with training in physical healthcare for non-medical staff. • There were concerns about the use of on-call doctors in mental health act assessments. The Trust was required to demonstrate best practice in the application of the Mental Health Act. In addition, the review team also noted the following concerns that were directly related to the rationale for the multi-professional review on 18 July 2019:

	• There were concerns around trainee safety, particularly with regards to the issue of personal alarms, chaperones and appropriate lighting in areas where they were expected to move between sites. • Trainees also expressed concerns about the quality of patient care. The full report and findings from the previous quality review which the HEE review team took in to consideration can be accessed at: https://www.lpmde.ac.uk/var/plqru/medical-quality-management/qif/focus-areas/quality-reviews/quality-reviews-reports In addition to intelligence obtained through HEE led quality reviews, HEE were also made aware of the outcomes from a Care Quality Commission (CQC) well-led inspection of Goodmayes Hospital in July 2019. However, it should be noted that the report from the well-led inspection had not been published prior to the multi-professional review and that the informal feedback obtained was confidential and did not form part of the questioning by the HEE review team. The concerns outlined above prompted HEE to organise a multi professional review to assess the clinical learning environment as a whole. The rationale for incorporating other healthcare professional learners was to provide the HEE review panel with a clearer view of the learning environment with a view to providing increased clarity over the information previously obtained.
HEE intelligence sources	In advance of the quality review on 18 July 2019, the HEE London Quality, Reviews and Intelligence (QRI) team reviewed the following intelligence sources in order to inform the pre-review meetings and to further advise the quality review team: • General Medical Council National Trainee Survey (GMC NTS) 2018 and 2019 • National Education Training Survey (NETS) • Escalation of concerns
Supporting evidence provided by the Trust	In advance of the quality review on 18 July 2019, North East London NHS Foundation Trust submitted the following evidence to the HEE QRI team. All of the evidence was reviewed by the quality review team as part of the pre-review processes: • Updated Trust action plan • Quality Assurance site visit report • Quality and Safety Committee – Learning from Serious Events quarterly reports • Academic teaching registers • Annual Guardian of Safe Working Hours report 2018 • Freedom to Speak Up Guardian report 2018-19 • Simulation registers • Junior Doctor Forum minutes – January 2019, March 2019 and May 2019 • National Staff Survey • Joint Service Education Meetings – agendas and minutes • Practice Partners meeting – agendas and minutes • Case Study feedback (Summer School) • Summary feedback (Summer School) • All cohort evaluations from University of East London (UEL) • Reflective practice group terms of reference • UEL Simulation Timetable • Case presentations • Foundation case presentations • Medical Education Committee meeting – April 2019 • Undergraduate student feedback from 2018/19 • Occupational therapy student feedback forms • Staff survey findings 2018/19 • Staff survey action plan 2019

How HEE carried out this review	The multi-professional review was arranged for 18 July 2019 and the Trust was invited to submit supporting evidence to illustrate the clinical learning environment for all learners. The review team thanked the Trust for the time taken to prepare, collate and return the substantial amount of evidence received in advance of the actual review date. In addition to the evidence submitted by the Trust, the QRI team undertook a detailed analysis of other intelligence sources available to HEE. This included a review of the General Medical Council National Trainee Survey 2018 results, the National Education Training Survey (NETS) results from November 2018 and the Higher Education Institute escalation of concerns returns. Notification was also sent to the Higher Education Institutes that placed nursing and occupational therapy learners at Goodmayes Hospital. The Higher Education Institutes were invited to contact the HEE QRI team with any additional intelligence or feedback from their learners and to confirm numbers of learners who were currently on placement in relation to the departments being visited The purpose of requesting evidence from the Trust and for the internal HEE analysis was to ensure that the review team were fully prepared in advance of meeting the Trust and its learners on 18 July 2019. The evidence was discussed at two internal pre-review meetings held at HEE and which the review team and Higher Education Institutes were invited to attend and contribute to. The review on 18 July 2019 commenced with a meeting with Trust management, followed by a confidential session with the Freedom to Speak Up Guardian. This session was included to further understand whether learners had access to support should they have concerns around unprofessional behaviours and, in particular, whether any concerns had been raised around the culture of the department. The review team also held separate sessions with the psychiatry trainees and the nursing and occupational therapy learners. The same sessions were then held with the education and clinical supervisors for psychiatry and the educators for nursing and occupational therapy. These sessions allowed the review team to triangulate the information heard. However, the review team recognised that from the education and clinical supervisor session that there was only one consultant from the in-patient unit.
Summary of findings	The quality review team would like to thank the Trust for accommodating the on-site visit and for ensuring that all sessions were well attended. The quality review team was pleased to note the following areas that were working well: **Mental Health (all learners)** • The Trust has recognised the workload challenges in the busy inpatient unit with the recent appointment of an additional on-call doctor to work a twilight shift. **Psychiatry Trainees** • Teaching was generally well received and the educational experience in the community posts/placements was of good quality. In addition, the review team was pleased to hear that the medical faculty was able to access faculty development opportunities • There was evidence of good engagement of trainees with the Trust's education team and the visitors heard that doctors in training talked of being open and able to raise concerns with supervisors and the Director of Medical Education (DME). **Student Learners** • Student learners, including occupational therapist and nursing students gave good feedback about their learning experiences and indicated that they had regular access to reflective groups. • The current cohort of student learners agreed that they would recommend the Trust as a place to experience a broad range of clinical cases and a

large proportion of the current cohort would consider future employment opportunities within the organisation following graduation.

However, the quality review team also noted a number of areas that still required improvement:

Mental health (all learners)

- Doctors in training reported that they felt nursing colleagues put undue pressure on them not to record concerns. The team also heard from doctors in training a perception and degree of frustration that serious concerns raised by trainees to senior members of staff with subsequent onward escalation to board level did not appear to result in appropriate action.
- Several instances were reported that potentially impacted on patient safety:
    - The Psychiatry Emergency Team (PET) response time was highlighted as of concern: the review team heard of instances where the PET team had arrived with a 20-minute delay following a code-red emergency alarm.
    - Lack of immediate observation, risk assessment, responsibility and ownership of new patients arriving in the reception area of the Sunflower Unit was highlighted as a very serious concern.
    - Patients physical health monitoring on the ward was highlighted as an issue
    - The review team heard that specialty training levels four to six (ST4 to ST6) often experienced difficulties and delay in moving around the sites safely due to lack of passes and keys.
- The ongoing cultural problem in the relationship between professional groups, particularly when dealing with deteriorating patients during on-call shifts.
- The Situation Background Assessment Recommendation (SBAR) tool was a welcome addition but the review team noted that the medical trainees reported it was used infrequently and that nursing students seemed to be unaware of its use.

Psychiatry Trainees

- The Trust has effective processes for raising concerns, through Datix reporting systems, supervision conversations and Junior Doctors Forums (JDFs). All levels of psychiatry trainees present understood how to raise concerns. However, the review team found little evidence to suggest that serious concerns that had been raised were being actively followed up. Moreover, trainees neither received any feedback from actions undertaken nor were actively involved in the mitigation processes.
- The learning experience for doctors in training on the inpatient general wards at Goodmayes Hospital was felt to be poor with the majority of trainees reporting that they felt unsafe whilst on-call at Goodmayes Hospital.
- None of the psychiatry trainees that the review team met with would recommend the post to their peers, would not be willing for friends and family to be treated there and would not consider future employment opportunities at the Trust.

Quality Review Team			
HEE Review Lead	Dr Elizabeth Carty Deputy Postgraduate Dean HEE (London)	**School of Psychiatry Representative**	Dr Vivienne Curtis Consultant Psychiatrist Head of School for Psychiatry
HEE London Representative	Kathryn Jones Interim Regional Chief Nurse and Dean of Healthcare Education	**Foundation School Representative**	Dr Nicholas Rollitt Deputy Foundation School Director for north central and east London
External Nursing Representative	Davina Culley Head of Education – Diggory Division Central and North West London NHS Foundation Trust	**Primary Care Representative**	Dr Rachel Roberts Head of Primary Care Education and Development
NHS England / NHS Improvement Representative	Carl Owusu Senior Delivery and Improvement Lead NHS England and NHS Improvement (NCEL)	**Trainee Representative**	Megan Moxon-Holt CT1, Camden and Islington
Lay Member	Robert Hawker Lay Representative	**Observer (HEE)**	Andrea Dewhurst Quality, Patient Safety & Commissioning Manager HEE (London)
HEE Representative	Tolu Oni Learning Environment Quality Coordinator HEE (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
MH1.1	**Patient Safety** • Psychiatry trainees The review team heard of several instances where trainees felt that there was a risk to patient safety particularly around the arrival of new patients to the reception area of Sunflowers Unit. The review team heard that patients had been left unsupervised for a significant period of time and that there was no ownership for these patients. This lack of observation, risk assessment and ownership was highlighted by the review team as a serious concern and identified as a priority area for the Trust to resolve. The review team further heard that none of the trainees would be willing for friends or family to be treated as an inpatient at Goodmayes Hospital.	Yes, please see MH1.1 below
MH1.2	**Serious incidents and professional duty of candour** • Psychiatry trainees The review team heard that there had been occasions where the trainees believed that some of the physical health observations recorded by nursing staff were inaccurate and that this had the potential to negatively impact upon patient safety. The trainees advised the review team that these instances had been reported through Datix and escalated to the Director of Medical Education (DME).	
MH1.3	**Appropriate level of clinical supervision** • Mental health (all learners) The Trust was disappointed to hear that some concerns had been withheld due to staff members not being clear on the escalation process. The Trust recognised that there would need to be changes to the induction process to ensure that all staff understood how to escalate a concern and to whom.	

	The review team further heard that the Trust had implemented a system that defined the escalation process when clinical supervision levels were reduced. The Trust hoped that that this new system would enable them to be more proactive in addressing supervision levels. • Psychiatry trainees The trainees indicated to the review team that they often felt unsafe whilst working at Goodmayes Hospital, particularly when out of hours. The trainees highlighted the lack of support and communication as being major factors for this and cited examples of when the Psychiatry Emergency Team (PET) had been slow to respond to an emergency bleep with a violent patient, which had left the trainee feeling unsafe. The trainees also reported that at times they had been asked to either alter the response times on the official reports or to "turn a blind eye'. The trainees advised that these issues had been raised with the relevant education supervisor (ES). However, the trainees believed that when the ES had approached the PET lead regarding these instances that the PET lead had indicated that the trainee account of the situation was inaccurate. • Student learners The review team heard that mentors were not allocated before placement commenced and that the learners often felt that they had to take the initiative with regards to their learning with guidance and encouragement dependent on the allocated mentor. The learners also reported that their mentor would not always be available due to the different shift patterns.	Yes, please see MH1.2 below
MH1.4	**Adequate time and resources to complete assessments required by the curriculum** • Student learners The review team was informed that for some of the learners there had been difficulties with receiving a login to the information technology (IT) systems for when they started their placement and that this had initially impacted on their learning opportunities.	
MH1.5	**Access to simulation-based training opportunities** • Mental health (all learners) The Trust informed the review team that simulation training had been available within the department for a number of years and that this was now multi-professional. The review team also heard that there were multi-professional opportunities around leadership, perinatal and first line responder simulation and that registered and student nurses were able to access these training opportunities. The Trust also indicated that they were looking into making simulation training in situ and would be looking at ways to support general practitioners (GPs) in looking after patients more effectively.	

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.**		
MH2.1 .4	**Appropriate system for raising concerns about education and training within the organisation** • Mental health (all learners) The Freedom to Speak Up Guardian reported that staff tended to follow the advertised procedures for reporting concerns and confirmed that feedback would be given to the relevant staff member. The review team heard that the Trust would be raising awareness of the role of the Freedom to Speak Up Guardian and that the Trust was also part of the national support programme to train the trainer. It was noted that the Trust well-being ambassadors had met with teams to ensure that they were addressing bullying and harassment behaviours. The Freedom to Speak Up Guardian also confirmed that they would seek advice from Human Resources to ensure that the correct processes were being followed particularly in relation to dealing with staff wellbeing. • Psychiatry trainees The review team heard that trainees were encouraged to submit exception reports. However, the trainees highlighted that when they had submitted incident forms, feedback was not received promptly with one trainee reporting having to wait 18 months. The review team noted that not all of the ST1 to ST3 trainees had log in details to exception report but that not all of the ST4 to ST6 trainees did. The trainees confirmed that this issue had been raised within their junior doctor forum. The trainees highlighted to the review team that although they were aware of how to raise an exception reports, that they felt, at times, that the consultants were not familiar with how to properly manage these reports. The trainees also advised that they were not aware of how time off in lieu (TOIL) or payment resulting from an exception report was processed.	Yes, please see MH2.1a. 2.1b, 2.1c and 2.2d below
MH2.2	**Rotas** • Mental health (all learners) The Director of Medical Education (DME) reported that the regular team was the home treatment team based at Goodmayes Hospital. The Acute Care Assessment Team (ACAT), extracted from the home treatment team, continued this function out of hours whilst working with the acute Trust. The Trust recognised that the current model of operating with a low bed base meant that the threshold for admission was high. The Trust would like to develop a virtual team to be better equipped or more medically orientated to support the out of hours' service. The review team heard that ACAT was responsible for the initial assessment of the patient and that during 09.00 to 17.00 they had access to the relevant clinicians. The Trust also advised that there were systems in place to support ACAT in that function. In terms of rota gaps, the Medical Director explained to the review team that the Trust were looking at their recruitment processes, with gaps being potentially filled by agency staff. There was also a system in place to enable senior consultants to "step down" in order to fill rota gaps. • Psychiatry trainees	Yes, please see MH2.2a below

	sites The DME explained to the review team that there were currently three trainee's on-call out of hours; one trainee covered Barking, Havering and Redbridge, one trainee covered Whipps Cross and the third covered 11 wards and the section 136 suite at Goodmayes Hospital. The review team noted that out of hours only the specialty training levels one to three (ST1 to ST3) were given personal alarms and access keys to the wards. The ST4 to ST6 trainees cited this as another reason as to why they felt unsafe when working out of hours. It was also noted that there was a lack of telephone reception and that this had made communication difficult between the PET and the ST1 to ST3 trainee when calling for support. When asked about their on-call shifts, the trainees explained to the review team that they would have on average four admissions per shift, further explaining that a 'bad' shift could entail up to 12 admissions in addition to the high number of ward patients. The trainees further explained that with eleven wards at Goodmayes Hospital, that it was almost impossible to attend all wards when on-call, particularly when there was a seclusion review. The trainees also advised that the on-call consultant did not always contact the ST4 to ST6 trainee at the start of their shift and this had left trainees feeling unsupported and unclear on who to contact. The DME recognised that trainees had fed back difficulties with workload at Goodmayes Hospital and advised that the Trust was looking at ways to improve this. To this end, the Medical Director further explained that the Trust had ensured that the operational lead was involved in the daily handover meetings to help identify and resolve any issues and that feedback on this approach had been positive. • Student learners When asked about their on-call working rota, the learners informed the review team that they undertook night shifts but had not experienced any issues or incidents that would impact on patient or their own safety.	Yes, please see MH2.2b below Yes, please see MH2.2c below
MH2.3	**Handover** • Mental health (all learners) The DME explained to the review team that the Trust was looking into how handovers could be improved handovers but confirmed that the Situation, Background, Assessment, Recommendation and Decision (SBARD) tool had been promoted and adopted across the Trust. • Psychiatry trainees When the trainees were asked about the handover process currently in place, the trainees reported that they were to use the SBARD model, although commented that they did not feel that SBARD was being used consistently across the Trust. The trainees further reported that there had been occasions when they were unaware if a risk assessment had been completed before they saw the patient. • Student learners The learners indicated to the review team that they had participated in multi-disciplinary team meetings. With regards to the SBARD tool, the learners advised the review team that whilst this had been covered as part of their university teaching they were not aware of its promotion and application within the Trust.	
MH2.4	**Systems and processes to make sure learners have appropriate supervision** • Psychiatry trainees The review team heard that, at times, the trainees had been unclear on which consultant was responsible for each patient and that support varied when they were required to call a consultant, particularly when out of hours.	

	• Student learners The learners indicated to the review team that they had not been allocated mentors before starting their placements. The review team also heard that learners often felt that they had to take the initiative for their learning and that, at times, there was little guidance and encouragement.	
MH2.5	**Organisation to ensure access to a named educational supervisor** • Psychiatry trainees The trainees confirmed that they had all been allocated a named educational supervisor. • Student learners The learners confirmed that they had all been allocated a mentor.	
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.**		
MH3.1	**Induction** • Psychiatry trainees When asked about the induction programme that staff received at the Trust, the Medical Director highlighted to the review team that the Trust was looking at improving the induction programme to manage the expectations of trainees when working at NELFT. The DME further explained that the Trust had introduced a one-day programme to help augment the trainee's clinical skills as well as shadowing sessions with the on-call team. The trainees advised that whilst there were shadowing opportunities available, in reality it was not always possible. • Student learners The review team heard that the pre-placement visit was a key aspect of learning in advance of the placement starting. Through this the Trust was able to ensure that learners were equipped with breakaway techniques. The review team noted that all learners received a week of orientation, where their mentor was identified and any adjustments to shifts made (for example for childcare purposes). It was also reported that during this week orientation the learner would meet their mentor and have a security induction to ensure that they were prepared for practice. With regards to low secure environments, the review team heard that new learners were given an induction pack. However, the process was similar to those entering the inpatient wards with learners introduced to service users so that they had knowledge of pictorial care plans (particularly for those learners on learning disability wards). The review team noted that for occupational therapy learners, that the practice supervisors would not offer last minute placements to the higher education institutes due to the nature of the clinical learning environment.	Yes, please see MH3.1 below
MH3.2	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** • Psychiatry trainees	

	When asked how the department provided educational experience whilst training, the Medical Director explained to the review team that there were a high number of acute mental health cases and that if any trainee lacked bed-based cases, that these trainees were supported appropriately. The DME explained that the Trust had worked with neighbouring Trusts to discuss a broad range of opportunities available to learners. The DME also highlighted the taster programme for GP and foundation year trainees. The review team heard that the trainees felt the in-patient unit at Goodmayes Hospital did not meet their training and educational opportunities stent. However, the trainees felt that the educational opportunities were good in the community placements. • Student learners The Trust reported that there were significant development opportunities for learners and that the department was committed to creating positive learning opportunities. However, the review team heard that the learners would welcome the opportunity to be more involved in the patient management process, particularly around the administering of medications to patients. In terms of learning opportunities, it was noted that there was in house training on the Morris ward and that learners were encouraged to attend this. For the occupational therapy learners specifically, it was noted that there was a monthly Continued Professional Development (CPD) meeting that they were actively encouraged to attend.	Yes, please see MH3.2 below
MH3.3	**Protected time for learning and organised educational sessions** • Psychiatry trainees All trainees reported that the teaching times were protected but advised the review team that approximately one in four teaching sessions had been cancelled at the last minute. This refers to the MRCPsych course The review team heard that the teaching sessions were not always directly elated to the Membership of the Royal College of Psychiatrists (MRCPsych) examination and that the trainees did not always feel prepared to sit the examination, particularly Paper A, and that this then increased the pressure on them. Several trainees highlighted that if they were unable to attend their weekly teaching session that this teaching could be discussed at their weekly meeting with their consultant. The review team heard that access to the resources for teaching and lectures was limited and that trainees felt that this impacted negatively upon the teaching sessions. • Student learners The learners all indicated that their learning experiences were good and indicated to the review team that they had regular access to reflective groups.	
MH3.4	**Behaviour that undermines professional confidence, performance or self-esteem** • Psychiatry Trainees When asked about any bulling and undermining that may be happening at Goodmayes Hospital, the trainees cited numerous examples of bullying, undermining and poor inter-professional behaviours and relations. The trainees reported that there had been no improvement made to the culture despite the issues being escalated by the Medical Director and Director of Medical Education to the Director of Nursing. However, the review team heard that the trainees felt that they were starting to be listened to however there had	Yes, please see MH3.4 below

	yet to be any sign of improvement and the trainees were not confident that the Trust was encouraging learning from serious incidents. The trainees all indicated that there was a large amount of bullying and undermining at the Goodmayes and that they did not feel supported enough to raise this at their local faculty group. The review team felt from the information reported that there was a longstanding culture of intimidation and undermining, particularly about issues raised around patient safety by nursing staff at the site. • Student learners The learners indicated to the review team that they did not feel undermined or bullied. However, the learners reported that they had learnt to approach those members of staff who they felt were approachable and that they had, on occasion, experienced different attitudes from members of the team. The review team heard that from a student nurse view although there were a number of opportunities for exposure, some learners felt that there were undertaking a healthcare assistant (HCA) role. It was noted that observation was a key part of the training.	

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.

MH4.1	**Sufficient time in educators' job plans to meet educational 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.

MH5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** • Psychiatry trainees The DME explained to the review team that the Trust had looked at the foundation programme curriculum and highlighted the learning objectives required. The DME explained that this was one of the reasons why the foundation programme had received several green outliers in the 2019 General Medical Councils National Training Survey (GMC NTS).	

	• Student learners The review team heard that each leaner met with their practice supervisor to identify their learning needs for the placement.	
MH5.2	**Opportunities for interprofessional multidisciplinary working** • Student learners The practice supervisors highlighted to the review team that there were a large number of multi-disciplinary learning opportunities available to healthcare learners, with the Trust encouraging that they learn from junior doctors and occupational therapists.	
MH5.3	**Appropriate balance between providing services and accessing educational and training opportunities** • Psychiatry Trainees The review team heard that the trainees often felt that the high workload had impacted negatively upon their learning opportunities.	

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.

MH6.1	**Learner/staff retention** • Psychiatry Trainees The review team heard that there had been difficulties with Human Resources with some trainees not being issued with a timely contract of employment or had been paid incorrectly. The DME advised that there had been changes made to the Human Resources department and that the Trust was satisfied that the contract pay rate for the August intake was correct. The review team was disappointed to hear that when asked if they would consider applying for higher trainee positions within the Trust, all ST1 to ST3 trainees present indicated that they would not consider this. In addition, the ST4 to ST6 trainees would not consider applying for a consultant post within the Trust. The review team heard that the staffing issues at the Trust were an issue that had impacted on the progression of learners and that efforts made by the Trust to rely on locum staff was often unsuccessful due to the capping policies in place. • Student learners When asked if they would recommend the post to a peer, the review team was pleased to hear that all the learners would recommend their post. When asked if they would consider to working at Goodmayes Hospital after qualifying, most learners expressed they would. Reasons for their decision cited was convenience of location and the length of preceptorship compared to others	Yes, please see MH6.1a below

	trusts as this determined the minimum duration of achieving the next grade under agenda for change. The review team heard that the practice supervisors had received positive feedback from the student learners about their placements. It was noted that some of the placements within occupational therapy were specialist and that for these placements consideration needed to be given to the level of student placed there. The practice education lead agreed that a pre-placement visit was a key aspect. The practice supervisors indicated to the review team that they loved their jobs and looked forward to coming to work, and that it was this positive behaviour that provided a good team dynamic. The informed the review team that they felt confident in being able to raise concerns within the Trust and be listened to, being able to keep high standard for learning and encourage contributions from the support workers. The practice supervisors further indicated that they acknowledged each other and had good reflective practices in place.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
N/A			

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.**
MH1.1	The Trust to ensure that there is an urgent review of why protocol is not being followed and patients in the Sunflowers Unit reception area are being left unattended, without a risk assessment or observations and without anyone knowing who is clinically responsible for them. This unsafe practice must stop.	The Trust is to provide evidence that this has been implemented by 30 September 2019	R1.2
MH1.2	The Trust is to ensure that there is a review of the psychiatric emergency team (PET) actual response times and a more robust method of monitoring that.	The Trust is to provide evidence that this has been implemented by 30 November 2019.	R1.2
MH2.1a	The Trust to ensure that there is a clear SOP for how learners raising concerns can receive feedback on actions taken as a result.	The Trust is to provide evidence that this has been implemented by 28 February 2020.	R1.3

MH2.1b	The Trust to ensure that exception reporting log-ins are received and effective for induction for doctors on August rotation.	The Trust is to provide evidence that this has been implemented by 30 September 2019.	R1.13
MH2.1c	The Trust to ensure that consultant supervisors are trained on the importance of exception reporting	The Trust is to provide evidence that this has been implemented by 30 November 2019.	R1.5
MH2.1d	The Trust to ensure that all trainees are advised how TOIL or payment resulting from exception reports can be processed.	The Trust is to provide evidence that this has been implemented by 30 September 2019.	R1.5
MH2.2a	The Trust is to ensure that there is a clear, proactive and achievable plan for handling rota gaps which does not involve doctors being put under undue pressure to do extra shifts and incurs an emergency response only in a true emergency	The Trust is to provide evidence that this has been implemented by 30 September 2019	R1.12
MH2.2b	The Trust to ensure that all on-call trainees have access to all buildings including rapid access for emergencies	The Trust is to provide evidence that this has been implemented by 30 September 2019.	R1.12
MH2.2c	The Trust to ensure that there is a review of the learning opportunities when doctors are working on the inpatient unit including out of hours. There should be an expectation that on-call consultants will contact the higher trainees at the beginning of their shift to establish a relationship, encourage and identify learning opportunities and consulting seniors when necessary when on call.	The Trust is to provide evidence that this has been implemented by 30 November 2019.	R1.12
MH3.1	The Trust to ensure that new starters receive shadowing opportunities of the on-call team	The Trust is to provide evidence that this has been implemented by 28 February 2020	R3.6
MH3.2	The Trust to ensure that educational supervisors are reminded that they need to meet with their assigned trainee within four weeks of them starting to discuss learning needs in keeping with the curriculum requirements. This agreement must also be recorded in the trainee's portfolio.	The Trust is to provide evidence that this has been implemented by 30 September 2019.	R2.15
MH3.4	The Trust to ensure that there is an organisational development plan to improve the relationships between professional groups out of hours which involves all nurses and doctors in training who do on call work in the in-patient unit	The Trust is to provide evidence that there is a plan to address the culture within the department by 30 September 2019 but it is recognised that the culture change will be an on-going piece of work with the Trust will need to provide monthly updates to HEE on.	
MH6.1	The Trust to ensure that all trainees are issued with a contract of employment and are listed on the correct pay scale for their first month and subsequent months' work	The Trust is to provide evidence that this has been implemented by 30 September 2019.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
	None	**N/A**	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Feedback session to be held with the Chief Executive, Medical Director and Director of Nursing prior to the report being issued.	HEE / Trust
Consideration will be given as to the best timing for a follow-up review to assess progress; it is estimated that this will be in spring 2020	HEE / Trust

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Elizabeth Carty, Deputy Postgraduate Dean HEE (London)
Date:	05 September 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.