Health Education England

# St George's University Hospitals NHS Foundation Trust

## Endocrinology and Diabetes Mellitus

## Risk-based Review (on-site visit)

**Quality Review report**

**5 November 2019**

**Final Report**

Developing people for health and healthcare

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# Quality Review details

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| **Training programme / learner group reviewed** | Endocrinology and diabetes mellitus (EDM) |
| **Number of learners and educators from each training programme** | The review team met with five trainees ranging from internal medicine training level one (IMT1) to specialty training level six (ST6). The review team also met with clinical and educational supervisors from the EDM department and Acute Medical Unit (AMU), as well as the following Trust representatives:<br>• Chief Medical Officer<br>• Clinical Director<br>• Divisional Chair<br>• Associate Director of Medical Education<br>• Medical Education Manager<br>• Clinical and Training Leads<br>• Clinical Education and Leadership Fellow |

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| **Background to review** | EDM at St George's University Hospitals NHS Foundation Trust (St George's University Hospital) received five red and six pink outliers in the General Medical Council (GMC) National Training Survey (NTS) for 2019. The red outliers related to work load, supportive environment, induction, educational governance and study leave. This generated five actions for the Trust on the 2019 red outlier action plans. |
| **Supporting evidence provided by the Trust** | The review team received the following evidence from the Trust in advance of the on-site visit:<br>• latest appraisal dates of the EDM supervisors;<br>• details of the most recent EDM trainee exception report submission (which was from September 2018);<br>• confirmation that the EDM department did not have a Local Faculty Group (LFG), but that this was to be re-established in 2019; and<br>• confirmation that there were no Medical Education Committee meeting minutes available, due to a change in management and clinical leadership.<br><br>At the on-site visit itself, the review team received a document from one of the clinical leads on the AMU, outlining the department's strategy to address the GMC NTS results for 2019, which related to the EDM trainees' involvement with the general internal medicine (GIM) rota. |

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| **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.<br><br>The review team was pleased to note several areas of good practice, including engagement with trainees, weekly informal and formal teaching sessions and changes to trainees' timetables to cater to their preferred areas of focus.<br><br>Although the EDM department received a red outlier for the supportive environment indicator in the GMC NTS 2019, the review team did not hear of any bullying or undermining concerns from trainees based in the EDM department.<br><br>Health Education England (HEE) issued one Immediate Mandatory Requirement |

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| | (IMR) at the visit, as follows:<br>• When EDM trainees are on the high intensity rota, they miss out on the specialist training experience they require for acquiring their competencies in EDM. HEE stated that all specialty training level six (ST6) and above trainees in EDM must not be put on the high intensity on call rota. A Trust response to this IMR was due on 12 November 2019.<br>HEE also identified the following areas for improvement, which were verbally shared with the Trust at the visit and shared in writing the following day:<br>• The Trust needed to individualise trainees' rotas in order to meet their training requirements for general internal medicine (GIM) and specialist training, based on the specialty competency requirements.<br>• ST6 and above trainees were not to see more than eight patients on their clinic list. ST3 to ST5 trainees were to be supernumerary on the consultant clinic list initially and gradually worked up to seeing a maximum of eight patients on their own clinic list. This was to allow time for case discussions and improve access to educational opportunities.<br>• The department needed to encourage and support trainees to submit exception reports for additional hours worked, as well as missed educational opportunities.<br>• The department was to establish a LFG with a trainee representative in attendance.<br>• The department needed to change the timetabling of teaching sessions to fit within the working hours of trainees.<br>• The department was required to ensure there were rest facilities, as well as bleep-free break times incorporated into the 13-hour shifts when trainees were on call for GIM.<br>• No trainees were to be rostered on call or on night shifts as Duty Medical Registrar in their first week of joining the Trust. Prior to starting on call or night shifts on the GIM rota, trainees should have had a complete induction.<br>• The Postgraduate Medical Education team was to send out an email to all clinical supervisors and educational supervisors to make them aware of the Supported Return to Training (SRTT) process.<br>• Trainees were receiving bleeps for the diabetic nurses. The Trust needed to provide a separate bleep or system of contact for the diabetes specialist nursing team. |

| **Quality Review Team** | | | |
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| **HEE Review Lead** | Geeta Menon,<br>Postgraduate Dean for South London,<br>Health Education England | **Training Programme Director** | Maria Barnard,<br>Training Programme Director for Diabetes and Endocrinology Specialist Trainees, North Central London |
| **Lay Representative** | Jane Gregory,<br>Lay Representative | **Lay Representative** | Saira Tamboo,<br>Shadow Lay Representative |
| **HEE Representative** | Gemma Berry,<br>Learning Environment Quality Co-ordinator,<br>Health Education England | **HEE Representative** | Louise Brooker,<br>Deputy Quality, Patient Safety & Commissioning Manager (Quality, Reviews and Intelligence),<br>Health Education England |

| Educational overview and progress since last visit – summary of Trust presentation |
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| The review team heard that, on receipt of the GMC NTS 2019 results for EDM, the department's clinical and educational leads met to discuss areas for improvement and sought feedback from trainees in order to address their concerns. The EDM leads told the review team that they considered the trainees' involvement with the GIM rota as the main driver for the poor NTS results and they had discussed this with the AMU leads in an effort to facilitate change. Two out of three of the current higher trainees in EDM were rostered to work on the low intensity GIM rota, which allowed them to join some EDM specialty clinics. However, some of the trainees in the previous cohort had been rostered onto the high intensity GIM rota which had restricted their access to specialist training opportunities. The EDM leads said that the trainees preferred to be rostered onto the low intensity rota as it allowed them greater exposure to EDM.<br><br>The review team was informed that the trainees sometimes worked a 13-hour shift on the AMU, which should include 30-minute breaks every four hours. The AMU lead said that changes were being made to ensure they had a bleep-free uninterrupted lunch break for 30 minutes and the rota design was being reviewed.<br><br>The EDM leads advised the review team that they had listened to trainees' feedback and allowed them to rotate between supervisors every six months and to attend any of the endocrinology clinics (not just those run by their allocated supervisors) to provide a wider variety of learning opportunities.<br><br>Although protected teaching time was scheduled for trainees each week (with good attendance), the review team heard that LFG meetings were not taking place and there was no trainee representative confirmed for the department. The clinical and educational leads agreed to work with the Clinical Education and Leadership Fellow to establish LFG meetings.<br><br>The review team advised the clinical and educational leads that it was important to review individual trainees' levels and training needs before deciding upon their work schedules, to ensure they were getting the appropriate learning opportunities to meet their curriculum requirements.<br><br>The review team was told that there was no Director for Medical Education in post at the Trust, although the recruitment process was underway. |

# Findings

## 1. Learning environment and culture

| Ref | Findings | Action required? Requirement Reference Number |
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| **HEE Quality Standards**<br>**1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive learning experience for service users.**<br>**1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.**<br>**1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I).**<br>**1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.**<br>**1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.**<br>**1.6 The learning environment promotes inter-professional learning opportunities.** | | |
| EDM 1.1 | **Serious incidents and professional duty of candour**<br>The review team heard from the higher trainees in endocrinology and diabetes mellitus | |

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| | (EDM) that they had not reported any serious incidents for EDM to date. However, they had dealt with patient complaints and reports to coroners. The trainees told the review team that a common theme of complaints was communication breakdown between the families of patients and the teams managing them. Busy workload was said to prohibit timely discussions with families, so conversations were sometimes delayed.<br><br>The trainees informed the review team that there were occasionally communication barriers between teams. Consultants referred patients to one another but did not always inform the higher trainees who had cared for the patients. The review team heard that a medical error and subsequent patient complaint had occurred because of this lack of communication.<br><br>It was not stated which clinical environment these complaints and referrals related to. | |
| EDM 1.2 | **Rotas**<br><br>The review team heard from one of the educational leads for EDM that there were currently three higher trainees in the department and two vacancies. In the previous cohort, two of the higher EDM trainees covered the high intensity general internal medicine (GIM) on call rota and two covered the low intensity GIM on call rota (the fifth trainee was signed off early from the GIM rota as they had completed all of their compulsory GIM training). The high intensity rota involved weekday and overnight on call shifts and the low intensity rota required trainees to work evening shifts from 17:00 - 22:00, as well as some night shifts. The educational lead suggested that the EDM higher trainees preferred to be rostered onto the low intensity on call rota, because the daytime on calls and zero days on the high intensity rota meant that they could not attend specialist EDM clinics during the day.<br><br>Two of the higher trainees told the review team that they were currently both on the low intensity rota and occasionally covered evening shifts (17:00 – 22:00) but were not rostered to work nights. This was due to be the case until October 2020. One of the higher trainees was not rostered onto the GIM on call rota but was put on an unbanded rota and covered booster shifts and weekend on call shifts.<br><br>However, one of the educational leads told the review team that there was a possibility of one of the current EDM higher trainees being moved from the low intensity rota onto the high intensity rota.<br><br>The review team heard from the clinical lead on the Acute Medical Unit (AMU) that the GIM high intensity on call rota meant that higher trainees worked 13-hour shifts and should have a 30-minute break every four hours. As a result of the GMC NTS results for 2019 and subsequent departmental discussions, the clinical lead advised they had written a strategy outlining some proposed improvements to the rota. These included arranging bleep cover for 30 minutes between 12:30 – 13:00 to give the higher trainees an uninterrupted lunch break, and changing the rota design so that participation in the GIM rota was scheduled in blocks. This strategy document was shared with the review team at the visit.<br><br>When the trainees had worked on the high intensity rota at weekends (08:30 – 21:30), they said they took adequate breaks when they could but there were no scheduled times when they handed the bleep over to someone else.<br><br>The review team was concerned that participation in the high intensity rota would prevent trainees from achieving their required EDM competencies and experience and told the clinical and educational leads that the Specialty Advisory Committee recommended protected time for EDM training, at a minimum of six months and ideally 12 months, with no GIM on call duties.<br><br>One of the educational leads informed the review team that the EDM departmental leads did not have access to the GIM rota and also did not know where their internal medicine training (IMT) trainees were based. | Yes, please see EDM 1.2a<br><br>Yes, please see EDM 1.2b<br><br>Yes, please see EDM 1.2c<br><br>Yes, please see EDM 1.2d |
| EDM 1.3 | **Induction**<br><br>The higher trainees informed the review team that they had received a good local induction from one of the EDM clinical leads, which included an overview of rotas and supervision. The previous higher trainees also left a booklet for the new cohort of | |

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| | higher trainees but no specific handover document was available for EDM.<br><br>However, the review team also heard of occasions when EDM trainees were rostered to work out of hours on the Acute Medical Unit (AMU) when they were new in post. Trainees advised that they typically received only a very brief induction to the unit and were sometimes not shown where equipment was kept, taught how to order investigations or given the necessary security access. The EDM trainees reported that IMT trainees had provided them with most of the information they needed when starting in AMU and that they had not always felt supported by other staff.<br><br>The review team suggested that the trainees' first day at the Trust should consist of a corporate induction and at least half of the second day should focus on GIM, but with no practical duties. The clinical and educational leads advised that discussions were already underway with AMU leads to ensure new trainees were not rostered to work nights in their first week or last few days of rotation.<br><br>The review team heard from trainees as well as clinical and educational leads that there had not been any Supported Return to Training (SRTT) processes put in place for one of the higher trainees who had started their post in EDM following a year of leave (such as phased return and discussions with educational supervisor and SRTT Champion). It was suggested by both groups that this may have been because the rotation start date correlated with the trainees' return to training, so it was not obvious they had been out of the training programme. However, the trainee had received a call from HEE whilst on leave, so it appeared that the SRTT process had been partially followed but it was unclear whether the Trust had been formally advised of the trainee's situation or the support which should be made available. | Yes, please see EDM 1.3a<br><br>Yes, please see EDM 1.3b |
| EDM 1.4 | **Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience**<br><br>The review team heard from one of the educational leads in EDM that, as a result of trainee feedback (sought following the GMC NTS 2019 results) the departmental leads agreed that trainees could rotate between supervisors every six months and attend any of the endocrinology consultants' clinics. As each supervisor had a different sub-specialty area of practice, it was felt that this approach would give trainees a wider variety of learning opportunities and experience.<br><br>The review team also heard that some diabetes trainees required more diabetes-specific training and the department was able to offer them learning opportunities for all subspecialties. On induction, diabetes higher trainees were asked by their supervisors which areas of learning they would like to focus on and their training timetables were developed accordingly.<br><br>The educational leads for EDM told the review team that, for higher trainees on the Kent, Surrey and Sussex (KSS) training programme, their rotation at St George's University Hospital was their only opportunity to attend more specialised EDM clinics and their training requirements needed to be better addressed by the department. However, the educational leads did not think that the KSS and London trainees saw themselves as being treated differently. For every clinic across EDM, there was a post-clinic meeting open to all higher trainees. The review team heard from the higher trainees that traditionally, the London trainees covered the GIM rota as they had more opportunities to work in tertiary hospitals and gain specialist experience compared with the KSS trainees.<br><br>The review team asked the higher trainees whether they had exposure to specialist EDM learning opportunities. The higher trainees informed the review team that these opportunities were mainly provided through the Trust's specialist EDM outpatient clinics, although occasionally through inpatient referrals. EDM was an outpatient-based service and the Trust provided a range of clinical experience that some trainees had not had before and would not have access to at other trusts on either the South London or the KSS training programmes. The higher trainees informed the review team that the EDM supervisors were content for them to join whichever clinics they wanted experience from, although the diabetes follow-up clinics were mandatory. | |

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| EDM 1.5 | **Protected time for learning and organised educational sessions**<br><br>The review team heard from both the higher trainees and educational leads that there was protected teaching time each week, including a journal club, endocrine investigation meeting (when trainees were given a topic to learn and present on) and biochemistry session, with good attendance by trainees. The trainees reported to the review team that they received good teaching compared with other Trusts they had trained at.<br><br>One of the educational leads said that there were informal EDM teaching opportunities every day, and formal teaching sessions three to four times a week. | |
| EDM 1.6 | **Organisations must make sure learners are able to meet with their educational supervisor on frequent basis**<br><br>The educational leads for EDM told the review team that on Tuesday afternoons, it was mandatory for all educational supervisors in endocrinology to hold case discussions with higher trainees. | |
| **2. Educational governance and leadership** | | |
| **HEE Quality Standards**<br><br>**2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.**<br><br>**2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.**<br><br>**2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.**<br><br>**2.4 Education and training opportunities are based on principles of equality and diversity.**<br><br>**2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.** | | |
| EDM 2.1 | **Effective, transparent and clearly understood educational governance systems and processes**<br><br>The educational leads for EDM told the review team that the teaching faculty (comprised of five trainers) met four times a year to discuss trainees' progress and training sessions. These meetings were not minuted previously, but since the GMC NTS 2019 results were released, minutes were now being taken to record activity, including trainee feedback. All trainees were now being asked to join at the end of the faculty meetings.<br><br>The review team stated that Local Faculty Group (LFG) meetings for EDM should be established, to include trainers and trainee representatives. The review team suggested that the Clinical Education and Leadership Fellow could help to set these up with the help of the Medical Education Manager.<br><br>The higher trainees informed the review team that they did not have a trainee representative for EDM at the Trust, although one of the trainees organised the rota. | Yes, please see EDM 2.1 |
| EDM 2.2 | **Impact of service design on learners**<br><br>When the review team asked what facilities were available to trainees at break times, the clinical lead for the AMU said that there was a staff room away from a clinical area, accessible 24 hours a day. However, the review team heard that a previous trainee had been reprimanded for sleeping in a chair whilst on a break in their night shift, even though 20 – 30 minutes of sleep during a night shift was recommended by the Royal College of Physicians. The review team noted that the Trust had received funding from the British Medical Association within the Learning and Development Agreement (LDA) payment for 2020 as part of a charter to build relaxation spaces and sleep facilities for | Yes, please see EDM 1.2b |

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| | trainees (approximately £30-60k) and encouraged the clinical and educational leads to determine whether any of this had been allocated to the department.<br><br>The review team asked the clinical and educational leads why they thought the GMC NTS 2019 results had shown workload to be an issue for higher trainees in EDM but no exception reports had been submitted since 2018. The educational leads said that some trainees would stay behind after hours for post-clinic discussions because they had not managed to attend the clinics themselves, due to covering staff shortages on the GIM rota. Furthermore, they lead said that it would be useful to recruit some permanent locum senior house officer-grade doctors and clinical fellows at middle-grade to cover most of the GIM rota and allow the EDM trainees to focus on specialty training.<br><br>Similarly, the trainees also told the review team that in their view, two additional higher trainees were needed in the EDM department to allow them to partake in a wider range of clinics, and that in some cases, attending clinics was only made possible by having core medical trainees to cover them on the inpatient ward. The trainees said that they found it difficult to deliver GIM ward duties and attend outpatient clinics at the same time, so in some cases they had spent a month on the GIM ward without doing a full specialist EDM clinic. They thought that two additional trainees would reduce the burden of GIM duties on individuals, provided they had not already completed the required GIM competencies. The trainees had been told by the departmental leads that two new higher EDM trainees would be starting in December 2019 and January 2020. The clinical and educational leads advised that one of these trainees was on sick leave and so the January start date was provisional, but an additional ST3 trainee was also due to join in January, so potentially there would be at least two more higher trainees in the department by early 2020.<br><br>When the trainees were asked why there had been no exception reports submitted for EDM since 2018, the review team was told that it was normal for the trainees to finish late because post-clinic discussions were always held after 17:00. If the trainees had not attended the clinics themselves, the post-clinic discussions were the only opportunity for EDM-specific learning. The higher trainees also said that when they had attended a clinic, they were usually very busy and so there was no time to dictate notes or letters until afterwards. They found it difficult to discuss patients with supervisors in clinic time and so this was done after hours. The trainees reported that this seemed to be an expectation of the consultants, who also stayed late. However, the trainees also told the review team that they did not mind staying late if they gained more learning opportunities.<br><br>When asked, the higher trainees said they were aware they could submit exception reports when they had missed a learning opportunity. However, the contract changes relating to exception reporting came into effect after they had become higher trainees, and so this was more ingrained in the working culture for junior trainees, but less so for higher trainees. The higher trainees expressed feeling uncomfortable about exception reporting.<br><br>The review team emphasised to the trainees that exception reporting was intended to encourage a work-life balance and that they needed to consider how they could avoid staying late and potentially getting 'burnt-out'. It was emphasised to the trainees that tiredness could lead to mistakes and that taking breaks was important. The review team suggested the trainees met with the Guardian for Safe Working Hours at the Trust. The trainees were also advised that the Trust was given a budget to ensure their trainees worked within their agreed hours and so they should not feel guilty, unprofessional or uncomfortable about exception reporting. This message was repeated to the clinical and educational leads and they were encouraged to support the trainees to change the working culture and leave at a reasonable time, for example by arranging to discuss patients before clinics, rather than afterwards. | Yes, please see EDM 2.2a and EDM 2.2b |
| | The review team heard from the higher trainees that when they started in post, the trainee clinic lists had been over-allocated and the trainees were responsible for informing the service manager of which patients and lists should be cancelled. These cancellations had not been made prior to the trainees' starting in post, even though the service knew with 12 weeks advance notice how many trainees there would be. The cancellations were made with less than six weeks' notice to patients. The review team | Yes, please see EDM 2.2c |

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| | suggested that a possible solution was to create 'partial booking' clinic lists that patients could not be booked onto until it was clear what the trainees were scheduled to do. The educational leads stated that their preference was for the higher trainees to only see a maximum of eight patients on their own lists and then to help consultants with their lists if they wanted to see more patients or if they had time available. The review team also advised that junior specialty trainees (ST3) should be supernumerary on the consultants' clinic lists initially to allow them to develop specialty knowledge and skills and to ensure patient safety.<br><br>The trainees thought that a lack of outpatient clinic space could become an issue if they were enabled to attend more specialist EDM clinics, although a 'registrar room' was being established.<br><br>The higher trainees advised the review team that the Inpatient Diabetes Specialist Nurses (DSN) did not carry a bleep known to the wards, so ward referrals for the attention of the DSNs would often go through to the higher trainees' bleep instead (at least one bleep a day) and they would act as a 'port of call' in between. The trainees said this disrupted their working day, including interrupting ward work or specialist clinic work, and the queries were not relevant to their training or their part of service provision. They therefore wanted this to be changed. The consultant clinical lead for diabetes said this had been an issue for quite some time and that there was an ongoing transformation project for diabetes and that this issue could be addressed through that project. Some clinical incidents had been raised previously because staff could not contact the DSN team via their non-urgent telephone line. | Yes, please see EDM 2.2d<br><br>Yes, please see EDM 2.2e |
| EDM 2.3 | **Organisation to ensure access to a named clinical supervisor**<br><br>The higher trainees told the review team that the clinical and educational supervisors in EDM had similar roles overall. The review team did not hear of any concerns regarding trainees' supervision and the higher trainees spoke highly of the education and support they received from their EDM clinical and educational supervisors. Based on trainee feedback sought following the GMC NTS 2019 results, the department agreed to allow EDM trainees to rotate between supervisors every six months to get a wider variety of learning opportunities and experience. The review team heard that there was space for trainees to meet with supervisors alone.<br><br>The review team was told the supervisors for IMT trainees remained the same throughout the year. | |

## 3. Supporting and empowering learners

| HEE Quality Standards |
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| **3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.**<br><br>**3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.**<br><br>**3.3 Learners feel they are valued members of the healthcare team within which they are placed.**<br><br>**3.4 Learners receive an appropriate and timely induction into the learning environment.**<br><br>**3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.** |

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| EDM 3.1 | **Behaviour that undermines professional confidence, performance or self-esteem**<br><br>The GMC NTS 2019 results for EDM showed a red outlier for the supportive environment indicator. When asked about this, the trainees did not report any bullying or undermining behaviour towards them in the EDM department. However, the review team did hear that there had been an occasion when a higher trainee had been working a night shift on AMU in their first week and a consultant had criticised them in front of other staff (not patients). | |

## 4. Supporting and empowering educators

**HEE Quality Standards**

**4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.**

**4.2 Educators are familiar with the curricula of the learners they are educating.**

**4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.**

**4.4 Formally recognised educators are appropriate supported to undertake their roles.**

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| | N/A | |

## 5. Delivering curricula and assessments

**HEE Quality Standards**

**5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.**

**5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.**

**5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.**

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| EDM 5.1 | **Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum**<br><br>With regards to the EDM trainees covering the GIM on call rota, the review team emphasised the importance of considering trainees' levels of experience and individual learning needs before planning their training schedule and rota arrangements. There was concern that some EDM higher trainees could be disadvantaged by participation in the high-intensity GIM rota and risk failing their Annual Review of Competency Progression (ARCP) due to not getting the required level of specialist training. The Trust was advised to consider the needs of trainees across medical specialties when planning the GIM rota to avoid compromising access to learning opportunities.<br><br>The review team confirmed that almost all medical trainees were dual-accredited for GIM and a specialty, but GIM training was only mandatory for three years, so some higher trainees could join the EDM department and not need to do any further GIM training. | Yes, please see EDM 5.1a and EDM 5.1b |

## 6. Developing a sustainable workforce

**HEE Quality Standards**

**6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.**

**6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.**

**6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs to patients and service.**

**6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.**

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| | N/A | |

# Good Practice and Requirements

| Good Practice |
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| The review team heard that, following a review of their General Medical Council (GMC) National Training Survey (NTS) results for 2019, the endocrinology and diabetes mellitus (EDM) educational and departmental leads arranged a teaching faculty review meeting and obtained feedback from higher trainees to identify areas of concern and where improvements could be made. |
| The review team heard that the EDM educational and clinical leads had listened to trainees' feedback and agreed that they could rotate between supervisors every six months and attend any of the endocrinology and specialist diabetes consultants' clinics (not just their supervisors' clinics), to get a wider variety of experience and training opportunities. |
| The review team were told that on induction, EDM higher trainees were asked by their EDM supervisors which areas of learning they would like to focus on and their training timetables were developed accordingly. |
| The review team heard from both the EDM educational and clinical leads and the trainees that there were a number of formal and informal local teaching sessions held each week, including journal club and endocrine investigation cases meetings. |

**Immediate Mandatory Requirements**

**Given the severity of an Immediate Mandatory Requirement, the risk rating must fall within the range of 15 to 25 or have an Intensive Support Framework rating of 3. This risk rating will be reviewed once the Trust has provided their response to the Immediate Mandatory Requirement.**

| Req. Ref No. | Requirement | Required Actions / Evidence | GMC Req. No. |
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| EDM 1.2a | When trainees are on the high intensity rota, they miss out on the specialist training experience they require for acquiring their competencies in endocrinology and diabetes mellitus. | All specialty training level six (ST6) and above trainees in endocrinology and diabetes mellitus must not be put on the high intensity on call rota. | S1 / R1.12 |

**Mandatory Requirements**

**The most common outcome from a quality intervention. The risk rating must fall within the range of 8 to 12 or have an Intensive Support Framework rating of 2.**

| Req. Ref No. | Requirement | Required Actions / Evidence | GMC Req. No. |
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| EDM 5.1a | The Trust should individualise trainees' rotas in order to meet their training requirements for general internal medicine (GIM) and specialist training, based on the specialty competency requirements. | Trust to provide evidence through EDM Local Faculty (LFG) minutes and/or trainee feedback by 1 March 2020, in line with the Health Education England (HEE) action plan timeline. | S1 / R1.12 |
| EDM 2.2d | ST6 and above trainees should not see more than eight patients on their clinic list. ST3 to ST5 trainees should be supernumerary on the consultant clinic list initially and gradually work up to seeing a maximum of eight patients on their own clinic list. This is to allow time for case discussions and improve access to educational opportunities. | Trust to provide EDM clinic templates by 1 March 2020, in line with the HEE action plan timeline. | S2 / R2.11 |

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| EDM 2.2a | The department should encourage and support trainees to submit exception reports for additional hours worked, as well as missed educational opportunities. | Trust to provide evidence of communication with EDM trainees regarding exception reporting by 1 March 2020, in line with the HEE action plan timeline. | S1 / R1.7 |
| EDM 2.1 | The department should establish a Local Faculty Group with a trainee representative in attendance. | Trust to provide minutes from the last two EDM LFG meetings by 1 March 2020, in line with the HEE action plan timeline. | S2 / R2.1 |
| EDM 2.2b | The department should change the timetabling of teaching sessions to fit within the working hours of trainees. | Trust to provide a copy of the EDM teaching timetable by 1 March 2020, in line with the HEE action plan timeline. | S1 / R1.16 |
| EDM 1.2b & EDM 2.2a | The department should ensure there are rest facilities, as well as break times (bleep-free) incorporated into 13-hour shifts when trainees are on call for GIM. | Trust to provide trainee feedback regarding GIM shifts/breaks by 1 March 2020, in line with the HEE action plan timeline. | S2 / R2.3 |
| EDM 1.3a | No trainees should be rostered to be on call or on night shifts as Duty Medical Registrar in their first week of joining the Trust. Prior to starting on call or night shifts on the GIM rota, trainees should have a complete induction. The Acute Medical Unit leads should work with the Clinical Education and Leadership Fellow to improve the induction process. | Trust to provide GIM rotas and an induction programme/timetable by 1 March 2020, in line with the HEE action plan timeline. | S1 / R1.13 |
| EDM 1.3b | The Postgraduate Medical Education team is to send out an email to all clinical supervisors and educational supervisors to make them aware of the Supported Return to Training (SRTT) process. | Trust to provide evidence of communications regarding SRTT by 1 March 2020, in line with the HEE action plan timeline. | S3 / R3.11 |
| EDM 2.2e | Trainees should not be receiving bleeps for the diabetes specialist nurses. The Trust is advised to provide a separate bleep or system of contact for the diabetes specialist nursing team. | Trust to provide written confirmation of new processes, i.e. referral pathway, by 1 March 2020, in line with the HEE action plan timeline. | S2 / R2.3 |
| EDM 1.2c | At ST6 and ST7 level, trainees should be offered six months of GIM-free specialty training. | Trust to provide evidence through EDM Local Faculty (LFG) minutes and/or trainee feedback by 1 March 2020, in line with the HEE action plan timeline. | S1 / R1.12 |
| EDM 1.2d | On call rotas are to be made available to EDM consultants. | Trust to provide evidence of communication with EDM consultants regarding on call rotas by 1 March 2020, in line with the HEE action plan timeline. | S1 / R1.12 |
| EDM 2.2c | The Trust should make arrangements to ensure there is adequate cancellation of clinics, with six weeks' notice prior to trainees starting, when there are gaps in the rota. | Trust to provide evidence of clinic cancellation processes in place, conducted by administrative and operational staff and giving patients 6 weeks' notice, by 1 March 2020, in line with the HEE action plan timeline. These processes must be in line with trainees' start dates and rota commitments and take account of unfilled training posts. | S2 / R2.3 |

| Minor Concerns<br>Low level actions which the Trust need to be notified about and investigate, providing HEE with evidence of the investigation and outcome. Given the low level nature of this category, the risk rating must fall within the range of 3 to 6 or have an Intensive Support Framework rating of 1. | | | |
|---|---|---|---|
| **Req. Ref No.** | **Requirement** | **Required Actions / Evidence** | **GMC Req. No.** |
| | N/A | | |

| Recommendations<br>These are not recorded as 'open' on the Trust action plan so no evidence will be actively sought from the Trust; as a result, there is no requirement to assign a risk rating. | | |
|---|---|---|
| **Rec. Ref No.** | **Recommendation** | **GMC Req. No.** |
| EDM 5.1b | Acute medicine clinical leads and EDM departmental leads should speak with colleagues at Epsom and St Helier University Hospital NHS Foundation Trust, who previously experienced GIM rota issues impacting upon specialty training and resolved them through the International Medical Training Initiative, available via the Royal College of Physicians. | S1 / R1.12 |

| Other Actions (including actions to be taken by Health Education England) | |
|---|---|
| **Requirement** | **Responsibility** |
| HEE to investigate whether SRTT processes, such as liaison with Trust SRTT Champions, are being followed to ensure trainees receive good return-to-training experiences. | HEE |

| Signed | |
|---|---|
| **By the HEE Review Lead on behalf of the Quality Review Team:** | Geeta Menon, Postgraduate Dean for South London, Health Education England |
| **Date:** | 19 December 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.