NHS
Health Education England

King's College Hospital NHS Foundation Trust

Gastroenterology (including Hepatology) and Neurology

Risk-based Review (on-site visit)

Quality Review report

19 November 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Training programme / learner group reviewed	Gastroenterology (including hepatology); and Neurology
Number of learners and educators from each training programme	**Gastroenterology (including hepatology):** The review team met with five higher trainees based at the King's College Hospital site, ranging from specialty training level four (ST4) to ST7, working in both the gastroenterology and hepatology departments. **Neurology:** The review team met with six higher trainees based at the King's College Hospital site, ranging from ST3 to ST6. The review team also met with clinical and educational supervisors from the gastroenterology, hepatology and neurology/neuroscience departments, as well as the following Trust representatives: • Corporate Medical Director • Director of Medical Education • Senior Medical Education Manager • Clinical, Educational and Training Leads • Clinical Education and Leadership Fellow

Background to review	This Risk-based Review was arranged to discuss the General Medical Council (GMC) National Training Survey (NTS) results for 2019 relating to gastroenterology and neurology at the Trust's King's College Hospital (KCH) site. **Gastroenterology (including hepatology):** Gastroenterology (including hepatology) at KCH received six red outliers and five pink outliers in the GMC NTS for 2019. The red outliers related to work load, supportive environment, adequate experience, curriculum coverage, educational supervision and study leave. This generated six actions on the Trust's 2019 action plan. (NB. Gastroenterology at the Trust's Princess Royal University Hospital (PRUH) site returned no responses in the GMC NTS 2019 due to less than three trainees completing the survey.) **Neurology:** Neurology at KCH received ten red outliers and five pink outliers in the GMC NTS for 2019. The red outliers related to overall satisfaction, reporting systems, teamwork, supportive environment, induction, adequate experience, educational governance, local teaching, regional teaching and rota design. This generated ten actions on the Trust's 2019 action plan. (NB. Neurology training is not conducted at the PRUH, and so there were no GMC NTS 2019 results available for this site).

Supporting evidence provided by the Trust	The review team received the following supporting evidence from the Trust in advance of the on-site visit: • Gastroenterology Local Faculty Group (LFG) meeting minutes from March and September 2019 • Neurology LFG meeting minutes from July and September 2019 • Medical and Dental Education meeting minutes from April and July 2019 • Supervisor training records for gastroenterology (including hepatology) and neurology

Summary of findings	The review team would like to thank the Trust for accommodating the review and extend their thanks to all of those who attended. The review team was pleased to note the following positive areas that were working well within gastroenterology and neurology at the King's College Hospital site, as outlined below: **Gastroenterology (including hepatology):** • The review team heard that there was a good educational governance structure and teaching faculty in place in both the gastroenterology and hepatology departments. • The review team found that there had been a noticeable improvement in the overall satisfaction of higher trainees since the GMC NTS results for 2019. The trainees felt well supported by their departmental educational and clinical leads. **Neurology:** • The review team heard that the department had implemented a rapid and appropriate response to the GMC NTS results for 2019. The restructured work programme now formally split acute and specialty work on the higher trainees' rotation. • The review team found that there had been a marked improvement in the overall satisfaction of the higher trainees since the GMC NTS results for 2019. • The review team heard that supervisors provided the same level of supervision, educational opportunities and support to locally employed doctors as specialty trainees, which the review team commended and hoped would improve retention to support workload issues. • The review team heard that the departmental supervisors felt well supported by the Trust's medical education team. However, the review team identified some areas of improvement within gastroenterology (including hepatology) and neurology: **Gastroenterology (including hepatology):** • Named educational supervisors should have appropriate time in their job plans put in place to fulfil their supervisory duties. • When a higher trainee is scheduled to work in an outpatient clinic, arrangements should be made for their on call bleep to be held by another member of staff. • The review team heard that gastroenterology higher trainees who were working on the general internal medicine (GIM) rota did not have the

opportunity to present their patients formally post-take and were therefore unable to complete Acute Care Assessment Tool (ACAT) assessments. This training requirement must be reviewed by the gastroenterology education lead with the consultants managing the GIM service and an appropriate action plan to meet this need put in place.

- Whilst higher trainees were able to attend specialty training days, the review team heard that formal cover was not provided by other staff so that they could attend GIM training days. The team require evidence of a SMART action plan to address this learning need.
- The gastroenterology and hepatology departments must provide the review team with clarity around all of the formal teaching sessions provided to higher trainees within working hours, and whether this is bleep-free.
- The gastroenterology and hepatology departments should explore the use of physician associates within both services, to ease the impact of any staffing shortages within the medical establishment.

Neurology:

- When higher trainees are rostered onto outpatient clinics, they should have an allocated clinic room available to them at all times.
- Workforce planning should be undertaken to mitigate against the predictable loss of junior doctor establishment, with further expansion of physician associates (which has been successful in other areas of the Trust) and other new roles including medical assistants and advanced care practitioners (ACPs) for which HEE can provide support within a workforce transformation programme.

Quality Review Team			
HEE Review Lead	Jo Szram, Deputy Postgraduate Dean for South London, Health Education England	**Head of School Representative**	Andrew Deaner, Head of School for Medicine, Health Education England
Lay Member	Kate Rivett, Lay Representative	**Lay Member**	Kate Brian, Shadow Lay Representative
HEE Representative	Gemma Berry, Learning Environment Quality Coordinator, Health Education England		

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

Gastroenterology (including hepatology):

The review team heard from the educational lead in gastroenterology that both the departmental leads and previous cohort of trainees had been surprised by the negative GMC NTS results for 2019. The leads had found it difficult to identify the drivers behind these results, so they arranged to meet with the trainees who had completed the survey, to try to understand their concerns. The educational lead highlighted that none of the trainees had previously been refused study leave and they had received departmental teaching each week. Their workload also had not changed since the previous cohort, whose NTS responses in 2018 had been more

positive. However, the educational lead acknowledged that the workload had always been heavy on the hepatology rotation, so the departmental leads had split the training posts to cover six months in gastroenterology then six months in hepatology, instead of one continuous year in each specialty (it was not stated when this change had taken place).

The review team was told by the educational lead in gastroenterology that higher trainees in gastroenterology were rostered onto the GIM on call rota. When their time on the GIM rota was added to their study leave time, the trainees received only approximately 24 weeks of gastroenterology specialty training per year.

The educational lead in gastroenterology advised that they had not received any exception reports from trainees to date. The department had, historically, always had senior higher trainees in post and the Director for Medical Education (DME) suggested that more senior trainees were less inclined to exception report than junior trainees. However, the educational lead described how the department had received a more junior cohort of higher trainees last year, who may have found their posts more challenging than the previous cohort, so a meeting had been introduced on Fridays to review referrals and conduct case discussions. The DME also said that departmental governance meetings were held with trainee representatives to discuss feedback on incident reporting.

The educational lead advised that the gastroenterology department did not have any physician associates in post, but they did have research fellows, although these were shared with other departments. An administrator was recently appointed to ensure clinic lists were not overbooked.

The educational lead for gastroenterology said that the supervisors in the department felt supported. There were no clinical or educational leads from hepatology present at the Trust presentation meeting. The review team was advised that the gastroenterology and hepatology departments were managed separately.

Neurology:

The clinical and educational leads in neuroscience and neurology told the review team that they thought the root cause of the negative GMC NTS results for 2019 was the rota and particularly the workload related to stroke cases. They described how the stroke rota was a busy consultant-led service that used to operate across two sites, with some of the highest patient numbers in London. The department had struggled with rota gaps for several months and had found it difficult to recruit good quality neurology clinical fellows who could fill these gaps. The review team also heard that trainees' access to teaching and specialty clinics had been an issue last year and it was difficult for the stroke consultants to get time in their job plans for supervision.

However, the review team heard that this year, the department had received good quality clinical fellow applications and they were now slightly over-established (by one additional non-training grade doctor and one additional clinical fellow), with a total of 16, rather than the minimum of 14 clinicians to cover the rota. The clinical and educational leads in neurology and neuroscience also told the review team that their physician associates had become a valuable and stable support for the consultant body and trainees, showing competency and dedication. The departments were exploring ways in which to further utilise this resource and maintain their (already good) retention levels.

The educational lead in neurology told the review team that the training rotations had recently been increased to four three-month placements per year (rather than three placements per year), with two placements focussed on acute inpatients and two placements focussed on outpatient specialty training. This was intended to prevent trainees on the outpatient rotation from having to fill rota gaps for the acute inpatient wards. Furthermore, where previously stroke and neurology services had been separated into two different departments, efforts were being made to bring these more closely together.

The neurology leads described how they had changed their rotation arrangements, so that there was always a consultant available to specifically support whichever trainee was covering ward referrals and Accident and Emergency cases (on the acute inpatient rota), which was apparently appreciated by the trainees and the trainees generally felt supported, according to the educational lead.

Furthermore, the educational lead in neurology advised the review team that the departmental leads had tried to ringfence teaching sessions so that as many trainees could attend as possible and regular monthly meetings were being held between leads and trainees.

With regards to both gastroenterology and neurology, the DME informed the review team that all trainees were aware of exception reporting. The review team also heard that the DME held trainee forums in parallel to departmental meetings and feedback/concerns were shared with the Trust's medical director. Staff vacancies

were said to have been the cause of a lot of issues at the Trust and significant effort had been put into recruitment. The DME said that the Trust was actively exploring non-medical workforce options, such as physician associates and clinical nurse specialists, to fill gaps in services. The Trust also had an established practice that all trainees had a supervisor, with supervision time in job plans, and the DME was confident that the supervisors were up-to-date with curriculum requirements.

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive learning experience for service users.

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.

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).

1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.

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.

1.6 The learning environment promotes inter-professional learning opportunities.

Ref	Findings	Action required? Requirement Reference Number
GN1.1	**Serious incidents and professional duty of candour** **Neurology:** The review team heard that some of the neurology trainees had submitted clinical incident reports but they had not received feedback on these yet. They said monthly governance meetings were held as part of their Friday educational sessions and Datix submissions were incorporated into these.	
GN1.2	**Rotas** **Gastroenterology (including hepatology):** The review team heard that two higher gastroenterology trainees were routinely rostered on the general internal medicine (GIM) on call rota, in blocks of three weeks covering nights (20:00 – 09:00) and twilight shifts. They were also rostered to do one in 20 week days on the GIM rota. The trainees described how the GIM rota arrangements meant that there were six weeks when only two trainees were covering the gastroenterology rota, with potential for clashes of annual leave. There were no clinical fellows rostered onto the gastroenterology rota. There were eight gastroenterology beds split between wards, but the trainees would review and manage gastroenterology patients on general wards if required. The review team heard that gastroenterology ward rounds were held twice a week with consultants. A board round was conducted every day and trainees saw new patients every day. The trainees told the review team that they thought they would be able to	

	find a supervisor to support them with new patient cases or any cases they were concerned about whilst working on the wards. The gastroenterology trainees told the review team that the GIM weekday shifts were not a heavy workload burden. However, whilst working on the GIM rota, they had no chance to present their patients formally, post-take. They said that completing acute care assessment tool (ACAT) assessments was difficult. The review team heard from one of the gastroenterology supervisors that their perception was that the trainees were only rostered onto the GIM rota to help with service provision rather than to gain learning opportunities, due to the lack of feedback they received on a post-take ward round. The review team was advised that clinical fellows were rostered onto the hepatology rota and they covered on call evening shifts. The higher trainees suggested that there were a lot of trainees keen to specialise in hepatology, hence why clinical fellows were willing to fill the rota gaps. They said that weekday on call shifts did not exist in hepatology but the higher trainees would each hold the referrals bleep for two months. The higher trainees in hepatology covered weekend on call shifts, which included the post-transplant ward round and hepatology ward round. The review team heard there was always a consultant on site whilst they were on call, to supervise the trainees on call. They did not mention night shift arrangements. **Neurology:** The review team heard from both the departmental leads and trainees that the rota had been changed since 2018 to encompass two divisions – acute inpatients and specialty outpatients – with two alternate blocks of each division per year (three months per block). There was one higher trainee rostered to cover neurology at weekends, but the review team heard there was always a consultant on site until 17:00 and the trainees found them to be approachable. The trainees advised that the weekend shifts were particularly busy, mainly with stroke cases, but the Accident and Emergency (A&E) team was generally very helpful, as were the stroke nurses, who would usually call the on call trainees to offer help. There was sometimes a stroke nurse available overnight. The review team heard that there was always a more senior (to the higher trainees) second on call doctor rostered between 08:30 – 17:00. Evening shifts were said to be busy but these were just for four hours and then a handover would take place with the night shift team. Furthermore, the trainees and supervisors told the review team that a new process had been implemented whereby core/internal medicine trainees (CMT/IMT) would attend all thrombolysis calls. There was also one physician associate on the stroke and neurology wards respectively that did not work out of hours or at weekends, but the trainees said they were a good source of support. The trainees told the review team that they received good support when they were on call from whichever consultant was rostered to cover acute cases and they could call them for help and advice whenever they needed it. However, whilst they could join ward rounds on the neurology ward and Hyper-acute Stroke Unit (HASU), there was not often the opportunity to do so, due to dealing with calls and other patient reviews. The trainees told the review team that they thought the rota arrangements were safe for the trainees and patients. They also thought that the increase in the number of higher trainees and clinical fellows in the department had helped significantly with addressing issues around rota gaps and avoided the higher trainees having to deal with a disproportionate amount of acute work. When the trainees were asked how they thought rota gaps could be addressed in the department, the review team was told that one option could have been to arrange for clinical nurse specialists (CNSs) to see patients who were outside of the thrombolysis window and review some patients on the wards. The trainees also suggested that some of the less experienced higher trainees could have benefited from the support of	Yes, please see GN1.2a Yes, please see GN1.2b

	physician associates, as those on the neurology and stroke wards were very efficient and worked at a high level of professional expertise. The trainees on the outpatient rota block advised that they were attending three to four clinics per week, which was at the lower limit of what they needed to meet their training and curriculum requirements. Therefore, they did not want any fewer clinicians on the rota, or else they would lose their clinic slots by having to fill inpatient rota gaps. The review team heard from one of the neurology supervisors that in 2018, when the department's rota 'collapsed', there had been some inflexibility from Trust management regarding allocation of pay to higher trainees willing to work additional night shifts. This had led to some conflict with the trainees, which was only resolved after some difficult discussions, and the supervisors said they hoped to see improvements regarding this type of situation in the future. The supervisors also thought that there was a need to engage in discussions with the Trust around establishing a rota based on the likelihood that some doctors would leave, or their plans would change in the course of the year and the department would no longer be over-established. The review team agreed it was important to plan for this eventuality and advised that the department needed provision for a non-training grade and non-doctor workforce.	Yes, please see GN1.2b Yes, please see GN1.2b
GN1.3	**Induction** **Gastroenterology (including hepatology):** The review team heard from the hepatology trainees that on induction, the consultants told them that they wanted to embed a positive culture in the department and the trainees implied that this had been their experience. **Neurology:** The review team were the neurology trainees starting on the inpatient rota block had received an induction that covered the stroke pathway, supervision and support whilst on call and they felt they had been eased into the post quite well. There was also always a more senior doctor as second on call to offer them support. When asked, the trainees did not highlight any required improvements to the department's induction process.	
GN1.4	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** **Gastroenterology (including hepatology):** The review team heard from higher trainees based in hepatology that they thought there were more learning opportunities at King's College Hospital (KCH) than at other trusts they had worked at, ranging from formal teaching sessions to more informal educational opportunities that were not necessarily labelled as such. They were also doing more therapeutic work than they had done before. The higher trainees each had individualised job plans covering different clinical skills and areas, such as post-transplant, liver intensive treatment unit (ITU), general endoscopy and referrals. The hepatology trainees covering acute inpatients were expected to present patient cases as a learning experience. Some of the more senior higher trainees in both hepatology and gastroenterology reported that they had their own outpatient clinic lists each week and they were getting good clinical experience. However, the review team was told that there was a potential issue around the more junior higher trainees not obtaining sufficient colonoscopy experience while based in hepatology. One of the gastroenterology supervisors suggested to the review team that, as a luminal specialty, the gastroenterology curriculum meant that trainees spent a lot of time learning how to become endoscopists but not gastroenterologists. They said that	

	clinics were rushed and busy and so there was little time for supervisors and trainees to discuss interactions with patients and receive feedback, and as result clinical learning encounters were lost. The review team suggested this was an issue with procedural-based specialties, but that the departmental leads could get involved in changing delivery of the curriculum, i.e. setting aside time for a teaching clinic that included interesting cases and spending more time with each patient. One of the hepatology supervisors agreed that it was important for trainees to understand the natural history of chronic diseases. All of the higher trainees in hepatology and gastroenterology told the review team that they would recommend their training post to colleagues. **Neurology:** The review team heard from the neurology trainees that they were exposed to useful learning opportunities that enabled them to complete their workplace assessments. They told the review team that they would recommend their training post to colleagues.	
GN1.5	**Protected time for learning and organised educational sessions** **Gastroenterology (including hepatology):** The review team heard from the higher trainees that there were weekly Wednesday morning teaching sessions held at 08:00, open to gastroenterology and hepatology trainees, and the trainee rostered on nights that week was also encouraged to attend. However, the review team was made aware that this teaching session was outside of the trainees' paid working hours and that there were no formal teaching sessions for hepatology trainees in working hours. The higher trainees in hepatology told the review team that they liaised with the department's clinical fellows to ensure there was sufficient cover for training and study days. Each of the hepatology trainees had slightly different job plans but were expected to attend all in-house training sessions. The review team heard that the gastroenterology trainees were expected and able to attend regional specialty training days but formal cover was not provided by other staff so that they could attend GIM training days. They were also able to attend journal club on Monday lunchtimes, attended by a consultant and open to hepatology trainees. **Neurology:** The neurology trainees told the review team that when they were on the outpatient rota block, they had local teaching sessions on Wednesday and Thursday lunchtimes and an educational half-day every Friday. Trainees rostered onto the inpatient rota block (four at a time) could not attend these educational sessions as they were unable to take calls due to poor telephone reception in the teaching area. However, they were able to attend the same sessions when they rotated onto the outpatient block, so they did not miss out on these learning opportunities. With regards to regional teaching, the trainees told the review team that the same rules applied as the local teaching programme, being that those rostered on the inpatient rota block were not able to attend. However, the regional teaching programme repeated every two to three years, so the trainees said they could eventually catch up if they had missed a session previously.	Yes, please see GN1.5a Yes, please see GN1.5b Yes, please see GN1.5c

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.

2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training. **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.** **2.4 Education and training opportunities are based on principles of equality and diversity.** **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.**		
GN2.1	**Effective, transparent and clearly understood educational governance systems and processes** **Gastroenterology (including hepatology):** The review team heard that the gastroenterology and hepatology departments were managed and led entirely separately, with different faculty meetings. The supervisors in gastroenterology advised the review team that their Local Faculty Group (LFG) meetings were held as part of their departmental meetings every two to three months on Wednesday afternoons and were well-attended by consultants and higher trainees. Trainees were contacted before the meetings to ask what they wanted to include on the agenda and often the meeting discussions would cover whether trainees were receiving adequate training experience. Trainees' progress was not discussed formally at these meetings but rather at consultant meetings held on Mondays. The hepatology supervisors told the review team that LFGs were not held formally but they did conduct regular consultant meetings with a standing agenda item on education. The findings of these meetings were fed into and discussed at their care group meetings. NTS results had also previously featured on the department's risk register. The supervisors said they held separate regular meetings with trainees, including at teaching sessions on Wednesday mornings. When asked by the review team, neither the trainees in hepatology nor gastroenterology were aware of any trainees attending LFG meetings, but the hepatology trainees confirmed that they had a named trainee representative for the department. The review team was told that there was no trainee representative for gastroenterology. The gastroenterology trainees told the review team that they were aware of consultant departmental meetings but not of educational supervisor meetings to receive feedback. **Neurology:** The review team was told that one of the higher trainees in neurology was a trainee representative (known as a 'lead registrar') and attended a meeting each month with the department's educational lead and administration team. This was one opportunity to raise concerns on behalf of the trainees, but concerns were also discussed in ward meetings on Fridays when patient cases and pathways were reviewed. The trainees said that this seemed to work, and they felt listened to. They were complimentary about their trainee representative. The review team was pleased to hear that LFG meetings were held every month, led by the Training Programme Director and attended by educational supervisors and the service manager. The trainee representative had attended some of these meetings. The supervisors told the review team that the meetings were minuted and once the trainee representative had left, the group would discuss potential trainees requiring additional support. The supervisors said that common discussion topics were rotas, lack of clinic rooms and ways to improve training.	

GN2.2	**Impact of service design on learners** **Gastroenterology (including hepatology):** The review team heard from the hepatology trainees that it took time to acclimatise to each of their differing job plans but now they were more comfortable with what they were expected to deliver. The hepatology trainees advised that their outpatient clinic lists formed part of a larger hepatology clinic, with oversight from a floating lead consultant who would discuss cases with the trainees beforehand. However, the trainees reported to the review team that when they were carrying the referral bleep, they could get interrupted whilst in clinic with patients and they were currently unable to uncouple these two duties, due to each of the higher trainees' varying job plans. One of the hepatology supervisors told the review team that the changes introduced in 2018 through the new IMT programme put a strain on their department as they lost five CMT trainees quite quickly and found recruitment challenging. Some of the higher trainees then had to take on more of the CMT-level work and where they were hoping for career progression, they often felt they were 'fire-fighting' instead. Although the situation was more stable now, the supervisor said there was still an impact on continuity for all trainees and consultants in the department. The review team heard from the gastroenterology trainees that their general workload was manageable and reasonable. They told the review team that they had five gastroenterology clinics split between three of them; those rostered to work on the wards had one clinic and the other two trainees had two clinics each. They were allowed to cancel their clinics, except for the two-week-wait clinic. They said that their clinic lists were variable but not overwhelming and they had time in their job plans for administration and clinical correspondence. When asked, the trainees in both hepatology and gastroenterology confirmed that they knew about exception reporting processes and the review team encouraged them to submit exception reports for overtime and for missed learning opportunities. One of the hepatology supervisors told the review team that their trainees' office and respite environment needed to be revamped with new chairs and equipment. The review team heard that the trainees shared a very small area and the IT infrastructure was poor. The supervisors thought that these relatively small practical matters would make the trainees feel more valued if they were promptly addressed. The review team heard that the Trust's electronic patient records (EPR) system had recently stopped functioning during an IT upgrade and clinicians were forced to use paper drug charts for several weeks. **Neurology:** The trainees in neurology told the review team that clinic room space was an issue for their learning. They did not always have a room to themselves to see patients on their own clinic lists (approximately two new patients and two follow-up patients) and they were occasionally prevented from attending or helping with any extra clinics due to a lack of space. One of the trainees said this has happened to them twice in three months. The neurology supervisors told the review team that there were plans to open some general neurology clinics at another Trust site, which would allow more clinic space at the King's College Hospital site for the higher trainees to see their own patients. However, the review team was pleased to hear that trainees were able to complete their clinical correspondence and administration in working hours now that the rota had been changed and they were not covering on call and outpatient duties at the same time. One of the neurology trainees said that they were not aware that exception reports could be submitted in relation to missed learning opportunities, as well as overtime.	Yes, please see GN2.2a Yes, please see GN4.1b Yes, please see GN2.2b

	The review team was asked for advice from the neurology supervisors as to how their department could best accommodate IMY3 trainees who wanted experience in neurology. They also said it was not clear how many of these trainees the department might expect to have placed with them. The review team recognised that the neurology department did not have a history of joint posts with acute medicine, but some of the non-training grade (locally employed doctor) posts could be re-designed to include neurology, and suggested liaising with colleagues on the Acute Medical Unit (AMU) about this.	
GN2.3	**Systems and processes to make sure learners have appropriate supervision** **Gastroenterology (including hepatology):** The higher trainees in both gastroenterology and hepatology told the review team that they felt very well supervised by their consultants. The hepatology trainees said that they had one junior doctor to support them from 09:00 – 17:00 and one doctor at CMT/IMT level to support them whilst on call at night between 21:00 – 09:00. There was also an on call consultant on site to supervise both post-transplant patients and general hepatology patients (including liver bleeds) and a consultant for gastroenterology patients. The review team heard of one occasion when a gastroenterology trainee had conducted a clinic without the named consultant present, but they had made it clear they could be contacted by telephone and another consultant was also available in a parallel clinic to assist. **Neurology:** When asked, none of the trainees in neurology reported any issues with their supervision and amongst their trainee cohort, they felt well-supported by one another and discussed cases together in their shared office. They said that their educational supervisors were very proactive. The review team also heard that the neurology supervisors offered the same support to clinical fellows and non-training grade doctors as they did to the higher trainees.	
GN2.4	**Organisation to ensure access to a named clinical supervisor** **Gastroenterology (including hepatology):** The review team heard that all of the higher trainees in gastroenterology and hepatology had named clinical supervisors. **Neurology:** The review team heard that all of the higher trainees in neurology knew who their clinical supervisors were.	
GN2.5	**Organisation to ensure access to a named educational supervisor** **Gastroenterology (including hepatology):** The review team heard that all of the higher trainees in gastroenterology and hepatology had named educational supervisors. **Neurology:** The review team heard that all of the higher trainees in neurology knew who their educational supervisors were.	

	The review team heard from one of the higher trainees in neurology that they felt well supported throughout their first three months in post and had met with their educational supervisor.	

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 to achieve the learning outcomes required.

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.

3.3 Learners feel they are valued members of the healthcare team within which they are placed.

3.4 Learners receive an appropriate and timely induction into the learning environment.

3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

GN3.1	**Behaviour that undermines professional confidence, performance or self-esteem** **Gastroenterology (including hepatology):** The review team did not hear of any bullying or undermining concerns from the trainees in either gastroenterology or hepatology. **Neurology:** The review team did not hear of any bullying or undermining concerns from the trainees in neurology.	
GN3.2	**Access to study leave** **Neurology:** When asked, the neurology trainees did not express any concerns regarding their study leave.	

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.

GN4.1	**Sufficient time in educators' job plans to meet educational responsibilities** **Gastroenterology (including hepatology):** The review team heard that each of the hepatology supervisors had no more than four trainees under their supervision at present, but these supervisory responsibilities included CMT/IMT trainees and critical care and some of the supervisors felt pressure to increase the number of trainees they were supervising within their job plans. The review team was told that the supervisors wrote their own job plans, which were submitted for approval, and their time for supervision was currently nominal. Some of the supervisors expressed frustration that they could not find the time to conduct supervisory duties properly and that the Trust in general did not necessarily support job	

	plan allocation for supervision. The review team heard that the supervisors had previously asked the Trust if they could recruit physician associates to support them and the trainees in critical care, but this had not materialised, although their first physician associate was due to join the hepatology department shortly. The review team heard that the hepatology educational supervisors did not have the chance to raise issues around supporting programmed activity (SPA) in their annual appraisals, but discussed these with the Director of Medical Education (DME) in their educational accreditation meetings, which were conducted every three years. The educational lead in gastroenterology told the review team that they had specific time in their job plan for educational duties but the supervisors did not have any defined educational PAs allocated to support them. The educational lead said they felt well supported by their colleagues and peers in the department, as well as the DME, specifically in relation to assisting trainees who had been identified as requiring additional support. **Neurology:** The educational and clinical supervisors in neurology told the review team that they had two hours in their job plans (0.5PA) each week for their educational supervision duties. The educational lead had one PA and the rest of the educational supervisors had 0.5PA to support them. The supervisors had attended supervision training meetings with the DME previously, and the Trust provided regular ongoing meetings for supervisors every month, along with refresher courses, so they felt well-supported and described having quite a lot of free rein over their supervisory duties. They said that the Trust was increasingly recognising the importance of training and educational leadership. The supervisors also said that they offered clinical supervision to more junior trainees.	Yes, please see GN4.1a and GN4.1b

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.

GN5.1	**Regular, useful meetings with clinical and educational supervisors** **Gastroenterology (including hepatology):** Some of the trainees in hepatology and gastroenterology told the review team that they would have liked to meet with their supervisors more on a more formal, timetabled basis. The meetings were sometimes coincidental in clinical settings, rather than planned. **Neurology:** The review team heard from the trainees that they had met with their supervisors twice during a placement (beginning and end) and felt that their offers of support were genuine. The review team advised that supervisors should meet with their trainees on a monthly basis.	

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.**		
	N/A	

Good Practice and Requirements

Good Practice
N/A

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.
	N/A		

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.
Gastroenterology (including hepatology):			
GN4.1a	The Trust is to ensure that all consultants have appropriate job plans in place for the supervisory roles that they perform.	The Trust is to provide job plans to Health Education England (HEE) for all supervisors in gastroenterology and hepatology that highlight appropriate measures are in place and agreed for the supervisory duties undertaken at a suggested PA allocation of 0.25PA per trainee for ES and 0.25PA for up to 4 clinical supervised trainees (see NACT guidance).	R4.2

		Please provide this evidence by 1 March 2020.	
GN2.2a	The Trust should ensure that when higher trainees are working within the outpatient clinic, their on call bleep is held by another member of staff.	Please provide evidence showing the process and plans put in place to make sure that bleeps are not held by trainees in the outpatient clinic, as well as feedback from trainees through Local Faculty Group (LFG) minutes highlighting that this process has been implemented and is sustainable. Please provide this evidence by 1 March 2020.	R2.3
GN1.2a	The Trust is to ensure that higher trainees in gastroenterology working on the general internal medicine (GIM) rota have the opportunity to present patients formally post-take and to complete Acute Care Assessment Tool (ACAT) assessments.	Please provide trainee feedback though trainee forums or LFG minutes indicating that higher trainees are able to present patients post-take to appropriate consultants and are able to complete ACAT assessments. Please provide this evidence by 1 March 2020.	R1.12
GN1.5b	The Trust is to ensure that higher gastroenterology trainees are able to attend GIM-specific training days.	Please provide a SMART action plan detailing how trainees will be covered to enable them to attend GIM training days. Please also provide feedback from trainees detailing that attending GIM training days is possible. Please provide this evidence by 1 March 2020. If no training day has been held by the submission deadline, please provide trainee evidence by 1 June 2020.	R1.16
GN1.5a	The Trust is to provide HEE with details around the formal, bleep-free teaching sessions provided to gastroenterology and hepatology trainees within working hours.	Please provide details of the bleep-free teaching sessions, including attendance levels, timings and topics covered. Please provide this evidence by 1 March 2020.	R1.16
GN4.1b	The gastroenterology and hepatology departments should explore the use of physician associates within both services, to ease the impact of any staffing shortages within the medical establishment.	Please provide evidence of future plans or business cases for the appointment of physicians associates into the gastroenterology and hepatology departments. Please provide this evidence by 1 March 2020.	R2.3
Neurology:			
GN2.2b	The Trust is to ensure that all neurology trainees have access to an allocated clinic room when rostered onto outpatient clinics.	Please provide evidence of an allocated clinic room available to neurology trainees when rostered onto outpatient clinics. Please provide this evidence by 1 March 2020.	R2.3
GN1.5c	The Trust is to mitigate the issues with poor telephone signal in the teaching area, to	Please provide a plan outlining how the Trust will address poor telephone signal in	R1.16

	ensure all trainees can attend scheduled teaching sessions.	the teaching areas. Please provide this evidence by 1 March 2020.	
GN1.2b	The Trust is to ensure workforce planning is undertaken to mitigate against the predictable loss of junior doctor establishment, with further expansion of physician associates and other new roles including medical assistants and advanced care practitioners (ACPs), for which HEE can provide support within a workforce transformation programme.	Please provide evidence of future plans or business cases for the appointment of physicians associates and other new roles into the neurology department. Please provide this evidence by 1 March 2020.	R2.3

Minor Concerns

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

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.
	N/A	

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:	Dr Jo Szram, Deputy Postgraduate Dean, South London
Date:	22 January 2020

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.