NHS
Health Education England

Bart's Health NHS Trust (Whipps Cross University Hospital)

Medicine

Risk-based Review (on-site)

Quality Review report

27 November 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Training programme / learner group reviewed	Acute internal medicine and medical specialities
Number of learners and educators from each training programme	The review team met with foundation, general practice (GP), core medical training and higher medical trainees, working across the medical specialties (including respiratory medicine, endocrinology and diabetes, geriatric medicine and gastroenterology). The review team also met with clinical/ educational supervisors from the department of medicine and the following Trust representatives: • Medical Director, Heather Noble • Director of Medical Education, Sujatha Thamban • Medical Education Manager, Vaishali Joshi • Clinical Director Whipps Cross Acute Medicine, Older Peoples Services & Stroke and End of Life Care: Simon Green • Respiratory Consultant and Educational Lead: Simon Quantrill • Acute Medicine Consultant and Educational Lead: Sherine Thomas/Samrat Bose • Gastroenterology Consultant and Educational Lead: Sami Hoque/Christian Ardley • Diabetes and Endocrinology Consultant and Educational Lead: Abdul Lakhdar/Kalpita Majumdar • Renal Consultant and Educational Lead: Gavin Dreyer/Saurabh Chaudhri • College Tutor: Kalpita Majumdar • Foundation Training Programme Director (FTPD): Dharshini Radhakrishnan • Associate Director of Quality for Medical and Dental Education, Nate Hill • Clinical Lead for Junior Doctors, Mathina Darmalingam • Cardiology Consultant and Educational Lead, Sandy Gupta

Background to review	This risk-based review was organised to explore a number of ongoing concerns that had impacted on the quality of education and training in the acute internal medicine and medical specialities at Whipps Cross University Hospital (WXUH). Health Education England also had concerns around the 2019 General Medical Council (GMC) National Training Survey (NTS) results.
Supporting evidence provided by the Trust	In advance of the quality review on 27 November 2019, Bart's Health NHS Trust submitted the following evidence to the HEE QRI team. This evidence was reviewed by the quality review team as part of the pre-review processes. • Medical Education Committee meeting minutes (04 July 2019) • Medical Education Committee meeting minutes (10 October 2019)

	• Educational Supervisor Training Compliance and Educational Appraisal • Faculty Meeting Minutes (28 August 2019) • Friends and Family Test October 2019 • Local Faculty Group meeting minutes (18 April 2019) • Local Faculty Group meeting minutes (19 July 2019) • Weekly Rota – week commencing Monday (04 November 2019) • Weekly Rota – week commencing Monday (11 November 2019) • Weekly Rota – week commencing Monday (18 November 2019) • Weekly Rota – week commencing Monday (25 November 2019) • DMEP Local Faculty Group meeting minutes (04 February 2019) • DMEP Local Faculty Group meeting minutes (10 June 2019) • Serious Incidents Involving Junior Doctors (December 2019 – March 2019) • Medicine at Whipps Cross Exception Reports (October 2018 – October 2019) • Whipps Cross Staff Survey • Bart's Internal Briefing Paper

Summary of findings	Health Education England (HEE) thanked the Trust for the work done to prepare for this review and for ensuring that the trainees were released from their duties to attend. HEE also thanked the trainees for their attendance and participation in the review. The review team was pleased to note the following areas that were working well: • The review team was pleased to hear about the appointment of a consultant clinical lead for junior doctors (site-based) and recognised that having a dedicated person for the role to support and solve issues for the trainees was making a significant difference to morale. The review team felt that this was an area of good practice which could be rolled out across the Trust. • The review team was pleased to hear that the education team was described by trainees as being supportive, organised and approachable. • The review team was pleased to hear that all trainees had access to structured, high quality and consultant-led teaching sessions for both their general internal medicine (GIM) and specialty training. • The review team was pleased to hear that the Critical Outreach Team was described as providing a reliable and supportive service to departments all day, every day. The review team identified the following areas of serious concern: • The newly introduced cardiopulmonary resuscitation (DNAR-CPR) online forms and treatment escalation plans (TEPs) as part of the Electronic patient records was currently delivering an unsafe practice. The trainees highlighted several incidents where the forms were not visible, expired because they had not been validated by a consultant within 24 hours, difficulties in identifying which consultants are responsible due to the acute on call cover system and when printed not being easily distinguishable in the paper notes. • The review team was concerned to hear that medically expected patients arriving in the emergency department (ED) were not being triaged or manged for ED until the medical team were able to review them. Due to exit block, patients were spending several hours in ED with delayed management.

- The review team was concerned to hear that the morning handover for medical patients was disjointed, unstructured and did not appear to be consistently led by consultants. The patients were often transferred to specialty wards without robust tracking leading to a risk of patients being missed.

The review team also noted several other areas for improvement:

- Whilst the review team found that engagement, face to face support and pastoral care and mentoring was clearly visible for specialty training level three (ST3+) trainees, it was felt that these areas of support could be improved for the foundation trainees.
- In terms of exception reporting, the trainees described the absence of a formal culture for raising exception reports and highlighted that exception reporting was not being actively encouraged by the department. The review team also found that the trainees would benefit from greater visibility and engagement from the Guardian of Safe Working Hours (GoSWH).
- The review team noted that the current rota arrangements was having a significant impact on the trainees' health and well-being. It was felt that a middle-grade rota with two weeks on-call in every four weeks was not sustainable and could have a detrimental effect on trainee and patient safety.
- The review team heard that not all of the outlier patients received a daily consultant review (Monday to Friday) and that there was no consultant review at a weekend. It was noted that if the patient was included on the weekend handover list that there would be a review by the ST3+ trainee but that this depended on the foundation or core trainee including the patient on the handover list.
- The review team was concerned over the lack of consultant review and responsibility for critical patients over a weekend, particularly those patients on the Coronary Care Unit (CCU) and the respiratory High Dependency Unit (HDU). This was described as potential risk to patient safety and as falling below the National Health Service England (NHSE) standards.
- The review team heard that there had been issues with regards to the portering service, particularly in relation to the surgical wards. Trainees reported that there had been several instances where they had portered patients and also described some instances of unprofessional behaviour from the portering staff.
- The review team heard that the training experience for trainees had been impacted by the information technology (IT) issues across Whipps Cross Hospital.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England	**Foundation School Representative**	Dr Keren Davis Foundation School Director
Head of School Representative	Dr Roshan Weerackody Training Programme Director Consultant Cardiologist	**Trainee Representative**	Dr Claire Mullender Medical Education Fellow

Lay Member	Robert Hawker Lay Representative	**HEE Representative**	Tolu Oni Learning Environment Quality Coordinator
HEE Representative	Andrea Dewhurst Quality, Patient Safety and Commissioning Manager	**Observer**	Naila Hassanali Quality, Patient Safety and Commissioning Officer

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

In terms of the 2019 General Medical Council (GMC) National Trainee Survey (NTS), the Director of Medical Education (DME) advised that the department had engaged with the trainees through the Local Faculty Group (LFG) meetings and this feedback had highlighted some areas of concerns specifically impacting on workload and the trainees' experience and welfare. As a response to this feedback, the DME advised that five themes had been identified which would improve the trainees' experience and, that for each theme, a working group had been established with consultant and trainee involvement. The review team heard that the five themes were:

1. Safe Medical Staffing: the review team heard that the department had taken steps to ensure staffing levels on the wards and within the acute assessment unit (AAU) were in alignment with recommendation set by the Royal College of Physicians (RCP) particularly for on-call working standards.
2. Weekend working: the review team heard that the department had conducted a baseline audit over six weekends, which had resulted in the benchmarking of junior doctors' responsibilities across several specialties including of those working in medicine.
3. Hospital at Night: the review team heard that a critical care outreach team was implemented and operational all day, every day, from 04 November 2019. It was also noted that there was a new electronic record for nursing observations.
4. Medical Handover: the review team heard that the department was looking to review the current handover system and it was proposed that there be handover between consultants at 08.00, 17.00 and 20.00. It was also reported that the department would be looking at the rotas to ensure visibility of medical trainees at these sessions.
5. Induction and local teaching: the review team heard that the Trust had taken further steps to improve the departmental induction. The DME reported that the Trust had was committed to mirroring the good teaching practices experienced by trainees across other specialties and as such the department had been working closely with medical trainees to improving access to teaching.

It was noted by the review team that the department had a target to implement at least three salient points from each of the working groups within the next six months so that the trainees started to see the benefits.

The review team heard that the site was predominantly receiving trainees at grades specialty training level three (ST3) and specialty training level four (ST4) and that the pressures experienced by these trainees had been directly linked to the frailty complexities received at Whipps Cross University Hospital (WXUH).

The Medical Director reported that the department was committed to improving trainees overall experience.

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
M1.1	**Patient safety** The review team heard that the trainees found the 'do not attempt cardiopulmonary resuscitation' (DNAR-CPR) to be a potential risk to patient safety and cited incidents where the forms had expired when a consultant had failed to provide a countersignature. The trainees further described the process as inefficient and although the trainees recognised that an electronic system was being developed from March 2020, they reported that the current processes were an issue. The trainees reported concerns around patient safety for those patients in the emergency department (ED) and highlighted the fact that there was a corridor culture of treatment which resulted in delays to patient care. The review team also heard that there were difficulties around the flow between ED and the medical take. It was reported that once the ED refer to the medical team, that ED cease treatment and it is then the medical team's responsibility to provide patient care. However, the trainees also felt that some of the referrals from ED were inappropriate for the medical team. The review team heard that there was an increased manager presence in ED to improve patient flow and corridor numbers. The patient flow from ED was highlighted as a patient safety issue. It was reported that the Acute Admissions Unit (AAU) were required to manage the majority of the workload which increased the pressure on the medical team. The core training level one and two trainees (CT1 and CT2) advised the review team that they had submitted Datix reports about specific instances related to compromised patient care. The review team further heard that once a patient has been reviewed by the medical team that they are taken to the AAU for post-take. Once a consultant review has taken place the patients are then triaged to a medical specialty ward. However, the review team was advised that there had been instances when a patient had been taken straight to the medical specialty ward thus by-passing AAU without the knowledge of the medical team which the trainees also felt was a potential risk to patient safety. The trainees highlighted the fact that from 17.00 to 21.00 on Fridays there was no cover for AAU which they perceived to be a potential risk to patient safety. The review team heard that those patients over the age of 80 were more likely to remain in AAU and face delayed care if they arrived after 17.30 on a Friday evening as there was no consultant responsible for the over 80 patients present. The review team further heard that these patients would not be reviewed by a consultant until the following day as part of post-take. However, it was also reported that unless patients were included on the weekend handover list that they would not be reviewed until the Monday morning; some patients over 80 were therefore not receiving a medical review over the weekend and the trainees felt that this was also a risk to patient safety. The review team heard of delays to patient transfers to specialist centres and cited particular challenges of transferring to the cardiology unit at St Bartholomew's Hospital	Yes, please see M1.1a Yes, please see M1.1b Yes, please see M1.1c
M1.2	**Serious incidents and professional duty of candour**	

	The review team heard that all the trainees understood how to raise a serious incident report on the Datix system. The review team heard of instances where a trainee had experienced a safety issue but was unsure how to report this via Datix as it related to behaviours from the portering staff within the ED. The review team heard that there were concerns around the nature of patients being allocated to the surgical wards and highlighted Primrose Ward as being a ward with inexperienced staff managing a large number of extremely unwell patients. The review team heard that the trainees did not feel that this ward was safe for patients and that although there had been instances where a Datix should have been reported, the trainees had not done so due to the complicated system and time-consuming nature of submitting a Datix report.	
M1.3	**Appropriate level of clinical supervision** The review team heard that the critical care outreach team was in place and provided good support to the trainees. There were no concerns raised by the trainees over the level of clinical supervision and trainees confirmed that they had never felt unsupported. The consultants were heard to be available, approachable and interested in providing a good learning experience for all levels of trainees. However, the review team heard that the consultant supervision in terms of foundation trainee development could be improved. The foundation trainees reported that whilst they had received good teaching from the CT1 and CT2 trainees, that they did not feel that all of the consultants were taking an interest in their development as a doctor and further advised that they felt learning was self-directed. The specialty training level three plus (ST3+) trainees advised the review team that there was good support from the consultant on the AAU. However, the review team heard that the trainees were not always clear on which consultant was covering during the day and evening and that there had been a lack of clarity over the time consultants were meant to arrive. However, the ST3+ trainees also reported that the consultants were approachable and contactable; there were no concerns over who to contact when on-call. It was noted that there was no consultant ward round on a weekend. The review team heard that patients need to be included on the weekend ward handover list and that the trainee was required to specify the actions to be taken for each patient. The review team further heard that if a patient was not included on the handover list, that they would not receive a medical review over the weekend. The review team also heard of concerns related to the supervision and management within ED. The foundation and CT1 and CT2 trainees advised that at times, on night shifts, that they had felt unsupported. The education and clinical supervisors advised the review team that the process for clinical supervision has improved over the past few years and that supervision was now more structured with greater consultant engagement.	Yes, please see M1.3a
M1.4	**Responsibilities for patient care appropriate for stage of education and training** The foundation trainees advised the review team that there had been some issues around workload at the start of the rotation in August 2019 when both senior doctors were on-call together. The review team heard that for approximately one month, the foundation trainees finished consistently late and beyond their scheduled end date of 17.00. However, the trainees advised that this issue has since improved. The review team heard that patient outliers had also been an issue at the beginning of the rotation in August 2019. It was noted that there was one ST3+ trainee allocated to outliers and that the foundation trainees were unclear on both their responsibilities and that of the ward clerk. As a result, the foundation trainees reported that they ended up completing administrative tasks not directly linked to patient care.	

	The ST3+ trainees advised the review team that the workload was manageable and appropriate to their level of training. However, the review team heard that there had been patient safety concerns related to patient transfers from the AAU to the specialty wards. All the trainees that the review team met with reported that there needed to be a more robust tracking system in place for managing patient transfers. In terms of clinic access, most of the trainees confirmed that they did have access to clinics as part of their timetable. However, for respiratory medicine the review team heard that attending clinics was often difficult for the CT1 and CT2 trainees as their attendance would mean leaving a foundation trainee on their own. The CT1 and CT2 trainees also felt that the Trust could arrange for trainees to attend other medical clinics in order to broaden trainee exposure. This would also ensure trainees were attending clinics when on-call shifts prevented them from attending their own specialty clinics. The ST3+ trainees confirmed that no clinic was undertaken without consultant supervision.	
M1.5	**Rotas** The CT1 and CT2 trainees reported that the rota was exhausting and not sustainable and that it felt like the trainees were covering the on-call rather than being given ward experience. The review team heard that the CT1 and CT2 trainees were allocated night shifts Monday to Friday with the weekend off, were required back in from Monday to Thursday day shifts before starting nights on a Friday for the weekend. The trainees reported that there were no breaks or days off and that there was no work / life balance for those two weeks every month. The trainees highlighted a risk to safety through processes and learning deteriorating when tired. The review team heard that the CT1 and CT2 trainees were required to undertake seven night shifts per month and that there was more night shifts on-call than day shifts on-call. There was no requirement for the foundation trainees to undertake night on-call; the foundation trainees were only allocated day on-calls. The review team also heard that the ST3+ trainees were on a one in four rota pattern. It was also noted that the ST3+ trainees were only allocated the Thursday off before a weekend on-call which comprised of three thirteen-hour shifts and were then expected to work Monday to Friday. The trainees reported this eight-day pattern to be exhausting and front-loaded. The foundation trainees reported that half of the on-call shifts were ward cover and half were on acute take. The review team heard that the trainees were able to clerk more patients on the on-call take. On-calls were felt by the foundation trainees to be a good learning experience. However, the trainees found that weekend on post-take felt more administrative as there was no consultant for patients aged 80 and over after 5pm. It was noted that on a 12-hour shift, the foundation trainees might only spend two to three hours clerking patients, the rest of the time was spent on administrative duties. The review team heard that there was one take ST3+ trainee and one ward ST3+ trainee for nights and weekends. There was no ward ST3+ trainee on Tuesday, Wednesday and Thursday after hours. From 16.30 to 21.00, the take ST3+ trainee was required to cover the ward. The review team heard that the system of having one trainee out of hours for the whole hospital could mean that patients on the ward were not seen as the trainee is pulled to take. The trainees advised that the locum registrar from 14.00 to 22.00 was supposed to help with take.	Yes, please see M1.5a Yes, please see M1.5b
M1.6	**Induction** The review team heard that all trainees had received a Trust induction on their first day and that they were also provided with their induction schedules/booklet and rotas six weeks in advance of commencing their posts. It was also noted by the review team that for those trainees who had experienced issues with the Trust induction process that this had been fed back. The foundation trainees advised the review team that they had received a week of induction that included lectures and general Trust information. The review team heard	

	that there were shadowing and learning opportunities for the new foundation trainees and that the information from previous cohort of trainees was found to be beneficial. The ST3+ trainees on the respiratory unit advised the review team that they had been shown around by one of the consultants and were given an opportunity to ask questions. The ST3+ trainees on the geriatric medicine unit advised the review team that they would have appreciated more information on how the on-calls are undertaken as part of their induction programme.	
M1.7	**Handover** In terms of the leadership structure in place for morning handover, the review team heard of an absence of a formal structured morning handover (Monday to Friday) and the lack of a consistent start time had resulted in trainees leaving later post-take after nights. The review team noted that the CT1 and CT2 trainees did participate in an informal handover at 09.00 to review the whole take list with the ward team. The trainees advised that it was not possible to undertake a morning handover on each ward. In terms of the handover arrangement for the AAU, the review team heard of handover arrangement occurring between 07:00 and 08:00 to the CT1 or CT2 trainee direct from the night team. It was felt that trainees would find an additional evening handover arrangement to be of value. In terms of the consultant engagement during weekends, the trainees described that the wards lacked sufficient consultant input but highlighted that the AAU benefited from regular consultant oversight with attendance from one discharge consultants and take consultant during morning ward rounds. In relation to the weekend handover arrangements, the review team heard that there was an extended handover of responsibilities at 17.00 but that this was not a review of patients on the ward. It was also noted that whilst there was a ST3+ trainee on a weekday evening, there was no trainee present on a Friday so cover for the AAU was diminished. The review team heard that the Trust had experienced difficulties in filling the 17.00 to 21.00 shift on a Friday. The review team heard that the CT1 and CT2 trainees only covered weekend days once every six months. The trainees commented that ward cover at weekends needed to be improved. It was reported that there was a considerable amount of patient reviews and overall the workload was high. The review team heard that there should be a CT1 or CT2, a locum senior house officer (SHO) and a F1 trainee. It was heard that the workload reduced as the foundation trainee became more experienced and able to manage patients. The review team also heard that there was no consultant cover on the wards for weekend days; instead there was an AAU consultant, a discharge consultant and a take consultant.	Yes, please see M1.7a
M1.8	**Protected time for learning and organised educational sessions** The CT1 and CT2 trainees reported that they attended regular weekly multi-disciplinary teaching sessions occurring from 16:00 till 17:00 but highlighted that they found difficulty in attending the regional teaching due to staffing and the current rota arrangement. The review team was however encouraged to hear that the department had taken steps to address the problem for the current cohort of trainees and, in particular, noted that for gastroenterology all regional training days had been scheduled into the rota. The foundation trainees described having protected time for teaching. However, the review team heard that the current scheduling of the teaching sessions (between 13.00 and 14.00 and then 15.00 to 16.00) meant that trainees frequently found themselves arriving late to the second teaching session, as they would return to clinical duties in between sessions. The trainees commented that the timing of their teaching sessions could be improved, for example, prior to advanced life support (ALS). It was also noted that whilst the quality of the teaching was variable, the trainees could see scope for	

	having more interesting teaching sessions. The review team also heard that several of the consultants were interested in teaching and delivered high quality sessions. The review team heard that the higher trainees received their regional teaching schedules six weeks in advance and that there had been no difficulty in applying for study leave. The trainees also confirmed that they had access to two hours of consultant-led, curriculum relevant teaching session, weekly. It was also noted that opportunities for quality improvement (QI) work was being encouraged by all consultants and focused on making a difference to the department pathways.	
M1.9	**Adequate time and resources to complete assessments required by the curriculum** The review team was pleased to hear that the consultants were happy to undertake work place based assessments (WPBAs) with the trainees. The CT1 and CT2 trainees commented that there had been an issue with completing Acute Care Assessment Tool (ACATs) but recognised that this issue was not unique to Whipps Cross Hospital. The ST3+ trainees also advised the review team that it was difficult to get ACATs for general internal medicine (GIM) as the trainees did not always post take patients. The CT1 and CT2 trainees also advised the review team that since a week without either day or night on-call shifts was rare, there was limited time on the wards which could then have a negative impact upon completion of WPBAs and training. The review team heard that the primary issue related to WPBAs for CT1 and CT2 trainees was for those on the Acute Care Common Stem (ACCS) programme as the curriculum was different to that for the core medical trainees and the ACCS trainees did not feel that their curriculum was fully understood by the consultants. For the ST3+ trainees, the review team heard that bronchoscopy WPBAs were difficult to achieve for the respiratory medicine trainees. Trainees were required to achieve two Direct Observation of Procedural Skills (DOPS) each and the review team heard that there had only been three cases to date. However, the review team heard that there was no issue with regards to pleural procedures. The education and clinical supervisors recognised that there were information technology difficulties which had affected the completion rate of WPBAs. The review team heard that the number of ACATs completed for core trainees had improved during 2018 and 2019. However, the education and clinical supervisors agreed that the way in which the trainees requested WPBAs was variable and that trainees should submit their WPBAs in a timelier manner post-take. It was agreed that there was a responsibility on both parties and that completion of WPBAs was not the sole responsibility of the supervisor. The review team heard that this was a regular discussion item at the Local Faculty Groups.	Yes, please see M1.9a

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.

M2.1	**Impact of service design on learners**	

	The review team heard that a fully staffed night shift was comprised of one ST3+ trainee and five CT1 and CT2s (one on the AAU, two on take and two on wards). It was reported that there were rota gaps on AAU and that it was standard to have at least one CT1 or CT2 vacancy. The review team heard that the CT1 and CT2 rota was intense in terms of the number of night shifts and that there was a lack of clarify on which consultant was responsible for post-take and at what time. The review team further heard that over half the patients were not included in post-take as they were either over the age of 80 or the trainee had left at 09.00. The foundation trainees reported finding the learning experience frustrating. The ST3+ trainees also reported that the night handover did not include the ward team and that it was difficult for the trainee covering the ward to know whom the sick patients were.	
M2.2	**Appropriate system for raising concerns about education and training within the organisation** The review team heard that not all the trainees were aware of how to raise an exception report and some of the foundation trainees reported that they had not received log-in details. The review team heard that for those trainees who had raised an exception report that there had been no learning or feedback received. The review team also heard that the foundation trainees had been told that they would need to meet with their education supervisor for all exception reports submitted and that this meeting would need to be at 08.00 or 17.00. The trainees reported that whilst the consultants were supportive and encouraged the trainees to exception report, they were often advised to take back the time informally rather than via exception reporting. However, the trainees highlighted a potential risk to patient safety if they were to finish their shift early.	Yes, please see M2.2a
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.**		
M3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The trainees confirmed that they were aware of the Guardian of Safe Working Hours and that the medical education team provided support and advise when required. However, the foundation trainees would welcome the consultants taking a greater interest in their development as a doctor.	Yes, please see M3.1a
M3.2	**Behaviour that undermines professional confidence, performance or self-esteem** When asked about the interaction between trainees and other departments within the hospital, the trainees reported that there were no concerns in relation to the nursing staff and other healthcare professionals. The review team heard that there was a positive working relationship clinically. However, the trainees also felt that the culture could be	

	improved and more supportive to trainees, for example, the review team heard that the trainees did not feel that the Trust was creating a culture of learning and teaching and were also unaware of who the executive team were in Whipps Cross Hospital. For respiratory medicine, the review team heard that, at times, the experience had been variable notably on the surgical ward (Primrose). It was heard that the majority of staff were agency and that there had been a number of information technology issues which had affected the learning experience for the trainees. The review team also heard of several instances of what was felt to be unprofessional behaviour from some members of the portering service. Overall the trainees recognised that the Trust was trying to improve the learning experience. The review team noted that the AAU consultants were very supportive and friendly which had resulted in a nice atmosphere for trainees to work with their seniors and other professions.	Yes, please see M3.2a
M3.3	**Less-than-full-time training** The review team heard that the department was not always aware of when a trainee was working less than full time and as a result had been included as a full-time trainee on the on-call and specialty rota. The trainees reported that there was no process for allocating less than full time trainees to the on-call rota.	
M3.4	**Access to study leave** All the trainees that the review team met with confirmed that there was a universal willingness to accommodate requests for relevant study leave.	
M3.5	**Regular, constructive and meaningful feedback** The review team heard of instances of what the trainees perceived to be patronising comments and feedback from some of the consultants and that this was often done in a joking style. The foundation trainees would welcome formalised feedback.	
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.**		
M4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The review team heard of clinical and educational supervisor appraisal occurring on a three-yearly basis. However, the review team also heard that some supervisors had not received an appraisal since 2013.	
M4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The review team heard that the education supervisors had difficulty in finding the time to support the trainees and that there was a focus on ensuring that there was allocated time within their job plans.	

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.

M5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The review team noted the challenge of ensuring that all ST3+ trainees received the required number of bronchoscopy procedures. The educational supervisors advised the review team that this issue had been raised with the Clinical Lead and would need to be further referred to the Head of School for Medicine. The review team heard that the trainees would be reluctant to recommend their training post to their colleagues given the pressure of the on-call rota. It was also highlighted that the CT1 and CT2 trainees were required to cover the ST3+ medical bleep on endocrinology and diabetes and that this could feel overwhelming for the trainees. The education and clinical supervisors reported that the department tended to receive more junior trainees (ST3 and ST4 level) than other sites across London and that this could have impacted upon their General Medical Council (GMC) National Trainee Survey (NTS).	Yes, please see M5.1a

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.

M6.1	**Appropriate recruitment processes** N/A	

Good Practice and Requirements

Good Practice

1. The review team was pleased to hear about the appointment of a consultant clinical lead for junior doctors (site-based) and recognised that having a dedicated person for the role to support and solve issues for the trainees was making a significant difference to morale. The review team felt that this was an area of good practice which could be rolled out across the Trust.

2. The review team was pleased to hear that the education team was described by trainees as being supportive, organised and approachable.
3. The review team was pleased to hear that all trainees had access to structured, high quality and consultant-led teaching sessions for both their general internal medicine (GIM) and specialty training.
4. The review team was pleased to hear that the Critical Outreach Team was described as providing a reliable and supportive service to departments all day, every day.

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.
M1.1a	The Trust is required to institute an interim plan to have the DNAR-CPR and TEP forms clearly signed, printed and visible in the patient notes from admission as appropriate. This system should continue until the new online system is tested to be robust and reliable.	Please provide confirmation from Clinical Director for Medicine or Trust Clinical Governance lead that this risk has been mitigated and adequate training or guidance provided to all staff. Please provide required evidence by 1 March 2020.	R1.1, R1.2 & R1.4
M1.1b	The Trust is required to ensure that patients are triaged and managed in the emergency department until transferred to the medical ward.	Please provide required evidence by 1 March 2020.	R1.2
M1.7a	The Trust is required to ensure that there is a robust and clear standard operating procedure for handover ensure there is no risk to trainee or patient safety	Please provide required evidence by 1 March 2020.	R1.14

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.
M1.1c	The Trust is required to ensure that all patients are seen daily; in line with NHS England and NHS Improvement guidelines. In line with this, the Trust should also ensure that there is a consultant ward round for patients on the coronary care unit (CCU) and respiratory high dependency unit every day.	Please provide required evidence by 1 March 2020.	R1.14
M1.3a	The Trust is required to ensure that all patient outliers receive a consultant review Monday through Friday and, that if they have been highlighted for review at a weekend, that this be undertaken by a ST3+ trainee at a minimum.	Please provide required evidence by 1 March 2020.	S1.1

M1.5a	The Trust is required to provide an update on the new rota arrangements for the medical trainees.	Please provide a copy of the rota and details of how this will, or has, addressed the burn-out as described by the medical trainees. Please submit the required evidence by 1 March 2020.	R1.12
M1.5b	The Trust is required to review the use of agency and locum staff over weekends to ensure that a) the medical trainees are given the opportunity to do more day shifts and b) that the out of hours work is equitably shared	Please provide required evidence by 1 March 2020.	R1.7
M2.2a	The Trust is required to ensure that there is increased awareness of the processes around exception reporting and the role of the Guardian of Safe Working Hours (GoSWH).	Please provide required evidence by 1 March 2020.	R1.1
M3.1a	The Trust is required to explore additional support for foundation medical trainees. This should include face to face support, pastoral care and mentoring to aid their development as doctors within medicine.	Please provide required evidence by 1 March 2020.	R3.2
M5.1a	The Trust is required to explore alternative options to ensure that all ST3+ trainees receive the required number of bronchoscopies as defined by the Royal College of Physician curriculum.	Please provide required evidence by 1 March 2020.	R1.19

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.
M1.9a	The Trust is required to review the current information technology infrastructure.	Please provide required evidence by 1 March 2020.	R1.20
M3.2a	The Trust is required to review the current arrangements for portering patients and, this should include a review of the professional interactions between the medical trainees and the portering staff.	Please provide required evidence by 1 March 2020.	R1.17

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 Indranil Chakravorty, Deputy Postgraduate Dean, North East London
Date:	27 November 2019

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.