NHS
Health Education England

Barking, Havering and Redbridge University Hospitals NHS Trust

Medicine (foundation)

Risk-based Review (focus group)

Quality Review report

10 December 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	This risk-based review was planned as a result of several on-going concerns around the level of clinical supervision that had impacted on the quality of medicine training being delivered for foundation trainees across Barking, Havering and Redbridge University Hospitals NHS Trust. Health Education England also had concerns around the significant deterioration of the 2019 General Medical Council (GMC) National Training Survey (NTS) results. At the Queen's University Hospital (QUH) site, fourteen red outliers were returned for: overall satisfaction, clinical supervision out of hours, induction, feedback, reporting systems, workload, teamwork, supportive environment, curriculum coverage, educational supervision and rota design. There were also six pink outliers received for: reporting systems, curriculum coverage, educational supervision, clinical supervision, clinical supervision out of hours and adequate experience across training at foundation level. The Medicine F1 GMC NTS results at King George Hospital (KGH) site only returned three pink outliers for: clinical supervision out of hours, induction and educational supervision across training at foundation level. HEE had previously undertaken a number of risk-based reviews to the Medical services across both sites over the previous four years: • Medicine (18 November 2015) • Foundation Medicine (17 October 2017) The most recent quality review on 17 October 2019 identified several longstanding cultural issues including a lack of clinical leadership and governance, poor rota design, lack of adequate experience and high workload. The review resulted in one Immediate Mandatory Requirements (IMR) being issued to the Trust. The rationale behind this focus group was to assess the progress made on the IMR, action plans from the most recent visit and to assess, through trainee feedback, any improvement made in the medical learning environment.
Training programme / learner group reviewed	The review team met with 36 trainees from foundation medicine working across both Queen's Hospital and King George Hospital.
Quality review summary	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.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England (London)	**Foundation School Representative**	Dr Keren Davies Foundation School Director Health Education England (London)
School of Medicine Representative	Dr Catherine Bryant Deputy Head of School of Medicine Health Education England (London)	**HEE Representative**	Andrea Dewhurst Quality, Patient Safety and Commissioning Manager Health Education England (London)

Lay Representative	Anne Sinclair Lay representative	General Medical Council Representative	Samara Morgan Principal Education QA Programme Manager (London)
HEE Representative	Tolu Oni Learning Environment Quality Coordinator Health Education England (London)		

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
FDNMed 1.1	**Patient safety** The trainees highlighted the constant foundation year one (F1) rota gaps on the on-call rota as unsafe due to the high workload and the seriously ill patients who required care. The review team heard that the Medical Acute Unit (MAU) at King George Hospital was currently managed by a range of short-term locum doctors and the lack of staffing had resulted in tension between ward responsibilities and clerking of patients. In addition, the trainees were also required to review patients in the emergency department. The trainees highlighted uncertainty on which consultant was responsible for each patient and advised the review team that there was not a regular ward round of all patients on MAU on weekdays and weekends which had led to uncertainty on what treatment had, and needed to be, given. The review team heard that this was a risk to patient safety. With regards to emergency medicine, the review team heard that patient flow was slow and that patient notes were not always transferred with the patient. A lack of accountability for patients from the emergency department was also described by the trainees and the review team heard that there had been instances when care	Yes, please see FDNMed1.1a

	was delayed as a result of the patient notes not being received by the relevant medical ward. For the MAU at Queen's Hospital, the review team heard that the consultant would review patients on a weekend and that the 56 bedded ward was divided into the Medical Referral Unit (MRU) for those patients under the age of 75 and the Elderly Receiving Unit (ERU) for those patients over the age of 75. Patients were supposed to be allocated to the respective section of the ward, but the review team heard that due to bed shortages patients were not always correctly allocated to MRU or ERU. The trainees also commented that patients could be moved at short notice between the MRU and ERU which has resulted in patients being missed off consultant lists and handover. The trainees highlighted a potential patient safety issue as they informed the review team that there was no consultant led daily ward round of patients but advised the review team that a core medical trainee or above would review every patient. In terms of the ERU at Queen's Hospital, the review team heard that this was primarily staffed by locums and the trainees felt that the learning experience on ERU was variable. All the trainees agreed that the learning experience was preferable and more supportive on the MRU. The review team heard that sick patients had been transferred along the Plus One or Plus Two policy and heard of examples where patients had been cared for unsafely in corridors and the middle of medical wards. Trainees further described that whilst the majority of patients were stable, that some critically unwell patients had been put at risk on wards as a result of this policy. The review team heard that the bed managers triaged patients and the result was Plus One or Plus Two. The review team also heard that there was an insufficient number of computers in the medical department and that there was often a delay in loading the relevant systems. This was felt to have an impact on patient safety as it could result in delayed care or the trainee having to make a clinical decision without all the patient information available to them.	Yes, please see FDNMed1.1b
FDNMed 1.2	**Serious incidents and professional duty of candour** The review team heard that the trainees were aware of the process for submitting a serious incident report through the Datix reporting system and that several of the trainees had done so. When asked why only a small number of trainees had submitted a Datix report, the trainees advised that this was due to time and workload pressures.	
FDNMed 1.3	**Appropriate level of clinical supervision** The review team heard that some of the consultants encouraged learning on the MRU and ERU and had made a conscious effort to support and teach the trainees. However, the trainees also reported that there were several consultants who, despite being on post-take, were unable to be contacted which resulted in the trainees feeling unsupported. The review team heard of several instances where the trainees had felt required to adjust a care plan given by MAU consultants in order to ensure patient safety. This was highlighted as an area of concern for the trainees at both Queen's Hospital and King George Hospital. The trainees praised the level of clinical supervision in renal medicine (particularly on Mandarin). The review team heard that all the consultants were approachable	

	and could be called at any time. The renal medicine ward was also reported to be supportive of learning. The review team heard that the learning environment on the endocrinology and diabetes ward at King George Hospital was variable depending on where the trainee had been allocated. It was noted that there could be improvements to the level of clinical supervision provided to trainees. The trainees reported that there were concerns about the Clinical Fellows and the level at which they had been appointed. It was heard that these concerns have been highlighted to the Guardian of Safe Working Hours (GoSWH). The trainees raised concerns about new foundation trainees rotating on to the MAU ward at King George Hospital as the trainees felt like they had to act like a ST3+ trainee on the ward to ensure safe patient care. The review team heard that the was a protocol as to who the F1 trainees could speak to within the hospital and advised the review team that they were not allowed to call microbiology or radiology. These departments were heard to only liaise with a core medical trainee or above. The review team heard that this also had a potential impact on patient safety when the trainees were unable to refer or seek clarification on microbiology or radiology.	
FDNMed 1.4	**Responsibilities for patient care appropriate for stage of education and training** The trainees were also responsible for covering care of the elderly wards, care of the elderly medical outliers, short-stay and neurology and it was noted that the F1 trainee would receive all the calls on a weekend where there was no core medical trainee (or locum) present. There was no consultant presence and the trainees reported high levels of stress in managing all the tasks and a significant number of extremely sick patients. The review team heard that support on a weekend was provided by the ward medical registrar on-call and if they were busy then the trainee would call the medical registrar on take. The review team heard that whilst there were supposed to be four trainees allocated to gastroenterology that this was not the case and it was therefore highlighted by the trainees as the department with the most unmanageable workload. It was heard by the review team that the consultants would leave after the ward round which normally finished at 13.00. It was noted that an evening ward round did not take place regularly. The review team also heard that there had been occasions when a single F1 had been left to manage all the tasks for 33 patients on the gastroenterology ward and up to four outlier patients. It was noted that the trainees had raised this issue in a departmental issue and that there was awareness of the heavy workload for the F1 trainee. The trainees also described working until 22:00 when the handover was supposed to be at 20:00. It was also noted that the on-call team would cover some of the gastroenterology patients when the team was struggling. The workload in gastroenterology was felt by all the trainees to be too much for a single trainee with no support from the consultants or other training grades and this had resulted in trainees breaching their working hours. The trainees also described the toll that this heavy workload had on their well-being and work to life balance. However, the trainees acknowledged the support provided to them by the Medical Education Team.	Yes, please see FDNMed 1.4a Yes, please see FDNMed 1.4b Yes, please see FDNMed 1.4b

FDNMed 1.5	**Rotas** The review team heard that despite the newly introduced rota that there remained significant variability of staffing levels on the wards, with some wards leaving a sole F1 trainee to manage 30 plus patients on their own. There was also perceived to be an over-reliance on the use of locum doctors on repeat shifts. The review team heard of concerns around rota coordination and the responsiveness of the rota coordinator to trainee requests submitted via email. The trainees cited lengthy delays in receiving a response from the rota coordinator and that this had resulted in uncertainty for the trainees. The trainees also reported that even when a change had been agreed by the rota coordinator that the rota often contained errors. The review team noted that the rota coordinator was not arranging locum cover and that there had been examples when there had only been one F1 and one ST3+ trainee covering the on-call which the trainees felt was unsafe for patients. It was also heard that for gastroenterology and care of the elderly that there have been weeks when the entire team has been scheduled on-call which has left two F1s to cover the ward. This approach has left the wards unstaffed and resulted in non-urgent tasks being delayed until the following week. This was felt by the trainees to be a potential risk to patient care and safety. The trainees also advised the review team that the rota coordinator was not actively checking annual leave across the ward before approving an annual leave request. An example was given of when a ward would have been left with two doctors out of seven and the trainees raised this as a risk for patient safety. The approval of leave was felt to be an issue across the Trust. Only the trainees assigned to the MAU were aware of which consultant had responsibility for the rota overall. However, it was heard by the review team that the consultant had recently passed responsibility for the rota to one of the ST3+ trainees and that this was the case for most of the medical wards. The review team heard that the ST3+ trainees were better at managing the rota but noted that they only had responsibility for their ward and team; they were unable to impact upon the overall medical rota. Whilst the trainees preferred the rota being managed by the ST3+ trainee, the review team heard that there was no administrative support for the ST3+ trainee or time in their job plans for rota management.	Yes, please see FDNMed1.5 Yes, please see FDNMed 1.4b Yes, please see FDNMed1.5
FDNMed 1.6	**Induction** The review team heard that the induction period for locum doctors, International Medical Graduate (IMG) doctors, locally employed doctors and Clinical Fellows was non-existent and that this group of doctors were not given access to information technology (IT) systems for several weeks. This lack of induction had resulted in the foundation trainees, who were also relatively new to the Trust, providing an on-the-job induction and supporting them in learning the National Health Service (NHS) systems and cultures. The review team further heard that there was no clinical supervision of this group of doctors and that, on occasion, the trainees had needed to question the treatment plan for patients to ensure optimal care was given. There was also concern that Clinical Fellows, some of whom had limited experience within the NHS had been allocated to the MAU which was one of the busiest departments with take and post-take. With regards to the induction received by the trainees, the review team heard that the primary issue was related to access to IT systems. It was noted that there were	Yes, please see FDNMed1.6

	eleven different IT systems which the trainees required access to in order to safely discharge their clinical duties and there was limited access to these systems at induction. This was highlighted by the trainees as a potential patient safety risk, particularly when on-call at night when the trainee was unable to access all relevant patient information. The review team further heard that Trust grade doctors only had a temporary log-in to the IT system and, as a result, had limited access. The review team heard of instances where the trainee would have to order bloods on behalf of a Trust grade doctor which was of concern to the trainees in terms of accountability. The review team heard that there was no formal induction in to what the trainees found the most challenging aspect of their role which was 'how to manage an acute take'. The trainees reported that one of the medical specialty trainee level three plus (ST3+) trainees had offered a voluntary out of hours session on how to manage an on-call. Although there were only limited places available the trainees reported that this would have been beneficial for all trainees as part of the standard induction programme as it covered how to prioritise patients as a new doctor in the hospital.	Yes, please see FDNMed1.6 Yes, please see FDNMed1.6
FDNMed 1.7	**Handover** The review team heard that the intensive medicine consultants were keen to teach and were contactable. On a weekend, the trainees reported that the intensive care medicine consultants would do a ward round until 15:00 and would talk through the patients with the trainee. Within respiratory medicine, the review team heard that handover was a printed list of all the patients. It was also noted that there was a consultant ward round every day but that on a weekend only those patients highlighted for review would be reviewed. In care of the elderly, the review team heard that on weekends there was no consultant for the ward round and that only those patients on the handover list would be reviewed. The review team heard that the care of the elderly consultants had a later start time of 09.00 which meant that they were not present at the morning handover at 08.30. This resulted in the overnight on-call take team handing over to the ERU and medical take. The trainees felt that as there was generally no ST3+ trainee present, that they felt it was the responsibility of the core medical trainee to relay relevant patient information to the consultants after handover was completed. Additionally, in gastroenterology, the ward round was not felt to be a thorough and comprehensive review which had left trainees unclear on the treatment plan for patients. Trainees also reported that they would be the sole F1 on-call. The review team also heard that the some of the consultants would not review patients out of hours and this had resulted in the trainee being uncertain on how best to manage the patient. In these instances, the trainees described making sure that the patient was stable, but all felt that this was not optimal care.	Yes, please see FDNMed1.7 Yes, please see FDNMed 1.4a Yes, please see FDNMed1.7

FDNMed 1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team heard that there was no opportunity for the trainees working in renal medicine to attend clinics. At King George Hospital, the review team heard that the F1 trainees did not clerk patients when on-call; the F1 on-call was responsible for the ward. It was also heard that as staffing numbers on the wards was low, the trainees could not be released to clerk patients given the ward pressures. The review team was advised that there had been occasions when the trainees could be released between 17.00 and 21.00 to clerk patients in the emergency department if the wards were quiet. The review team that at Queen's Hospital the trainees would clerk patients from 13.00 on the on-call shift.	
FDNMed 1.9	**Protected time for learning and organised educational sessions** The review team heard that there was one afternoon per month designated as foundation teaching but noted that this teaching did not take place in December or January. The trainees reported that they were able to attend teaching unless they were on-call. Whilst the trainees found the teaching useful, the review team heard that these sessions were not included as part of the rota and that if they were on-call, the trainee was required to seek permission from the rota co-ordinator and arrange cover for the on-call shift. The trainees praised the Medical Education Team for their assistance in resolving any issues with regards to attendance.	

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.

FDNMed 2.1	**Effective, transparent and clearly understood educational governance systems and processes** The review team heard that whilst the trainees were aware of the governance processes for submitting a serious incident report, they felt that the use of the Datix (IR1) form was used as a punitive measure inter-department. The trainees did not feel that the IR1 form was being used in the correct context in that it was being used as part of what the trainees perceived to be a blame culture. The review team also heard of instances when nurses had told trainees that they would be submitting an IR1 form unless a discharge summary was completed for a	Yes, please see FDNMed 2.1

	patient. The trainees did not feel that there was any learning when an IR1 form had been submitted.	
FDNMed 2.2	**Impact of service design on learners** The trainees reported that overall, they felt the Trust was under pressure and that there needed to be greater visibility and support from the senior executive team, particularly with regards to improving systems and processes. The review team heard that there was an overreliance on locum doctors when filling rota gaps and that there were regularly short notice rota gaps when the locum doctors failed to turn up for their shift. This then had an impact on the trainee workload and the review team heard of one instance where there was one foundation trainee and one core medical trainee covering 30 patients when a locum doctor called in sick for a few days. The trainees felt that the systems within the Trust needed improvement and cited examples of handwriting notes, handwriting blood bottles and faxing documents between departments. The unreliability of the systems used were also felt to have had a variable impact on workload. In terms of the MAU at King George Hospital, the review team heard from the trainees that they regularly felt harassed by the patient flow coordinator to provide discharge summaries. The trainees at King George Hospital did not find the role to be helpful. However, the trainees based at Queen's Hospital reported that the patient flow coordinator was excellent. The trainees also cited a lack of confidentiality at Queen's Hospital on the MAU ward, which the trainees described as large and open with the medical team visible to all when discussing patients; this had resulted in examples where the bed managers had been overheard by patients and relatives which had then resulted in the trainees facing some difficult conversations as to why they did not feel the patient could be discharged.	
FDNMed 2.3	**Appropriate system for raising concerns about education and training within the organisation** The review team heard that not all the trainees were familiar with the exception reporting process. The trainees also questioned when they would have time to exception report if they had stayed late or had a high workload. The trainees advised that some of the wards dealt with exception reports immediately and proactively identified time when the affected trainee was able to take time off in lieu. The review team heard that there a junior doctor forum had commenced in September 2019. However, it was noted that there were improvements to be made around the structure, how to minute and how to action these meetings. It was noted that there had not been any minutes circulated from the initial meeting in September 2019.	

FDNMed 2.4	**Systems and processes to make sure learners have appropriate supervision** The review team heard that the trainees were not required to do night on-call shifts. The review team heard that the MAU at King George Hospital was covered only by locum core medical trainees; there was no core medical trainee or consultant on the rota. The review team further heard that the F1 trainees were not in regular contact with the consultants and they were also unclear as to the escalation route when on-call.	Yes, please see FDNMed2.4a
	It was noted that the consultant on-call, or responsible for the specialty wards, was not always known or communicated to the trainees. Trainees described spending a significant amount of time looking for a consultant who may be willing to review their patients. If a patient required escalation, the trainee would call the ST3+ trainee covering the post-take and they would help the trainee develop a treatment plan so that the trainee did not feel unsupported. The review team heard that the trainees did not know how to escalate a deteriorating patient beyond the ST3+ trainee.	Yes, please see FDNMED2.4b
	The trainees further advised that although there was a board in the seminar room at Queen's Hospital detailing the names of the consultants on-call, that this was not always updated. The review team also heard that there had been instances where a trainee had called the on-call consultant at 15.30 about a patient and been told to wait until the next consultant came on-call at 16.00. The trainees raised this as a potential risk to patient safety. The review team heard that the trainees relied on the ST3+ trainees for support and advice when they were on-call on MAU over a weekend as, although there were acute care of the elderly consultants on-call they covered the acute short stay and ERU, the trainees were not given their contact details and so there was no consultant support available. The review team was pleased to note that for respiratory the trainees were supported and that the consultants made sure that the trainees knew who to call and how best to contact them. Renal medicine, intensive care medicine and MAU at Queen's Hospital along with cardiology at King George Hospital were highlighted by the trainees as departments with good consultant supervision and engagement.	Yes, please see FDNMED2.4a

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.

FDNMed 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The review team heard that the trainees found the Trust Medical Education team to be extremely supportive and the trainees valued the support that this team provided.	

FDNMed 3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The review team heard that none of the trainees met with would be happy for their friends and family to be treated at the Trust. The trainees reported that there appeared to be a culture of blame with staff using the Datix (IR1) form as an open threat against each other. This was heard to be a daily occurrence and for new trainees this was felt to be intimidating. It was also heard that the trainees felt there was a culture of defensive medicine at Queen's Hospital with the threat of an IR1 form coercing trainees into taking an action that they did not want to do. It was also felt that the nursing staff had the culture of calling and threatening the trainee with an IR1 form instead of listening. The review team also heard that there had been times when the trainees had felt pressured to work and the trainees cited examples of working when they were unwell and of cancelling planned leave in order to cover rota gaps. In acute medicine, the review team heard that this was a pressurised environment and that the trainees regularly felt harassed by other staff groups to either discharge or move a patient to release a bed. Pressure on the care of the elderly wards was a specific issue as a third of the patients were social and waiting on transfer to a nursing home. The trainees reported that they regularly felt under pressure to discharge patients who were improving but not fully medically fit. There were also reports of overtly rude and unprofessional behaviour of radiology doctors towards the foundation trainees who described being repeatedly subjected to humiliation.	Yes, please see FDNMed 2.1 Yes, please see FDNMed 3.2
FDNMed 3.3	**Academic opportunities** N/A	
FDNMed 3.4	**Access to study leave** N/A	
FDNMed 3.5	**Regular, constructive and meaningful feedback** The trainees also advised that the consultants on the MAU and renal ward were supportive, approachable and available to answer questions. The review team also heard that there was an end of rotation meeting for the acute medicine unit. However, the trainees reported that none of the geriatric medicine consultants were present. The review team heard from the trainees that in respiratory medicine at Queen's Hospital the consultants met with the trainees once a month and any issues were dealt with promptly.	

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.		
	N/A	

5. Developing and implementing 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.**		
	N/A	

6. Developing a sustainable workforce

HEE Quality Standards **6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.** **6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.** **6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.** **6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.** **6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.**		
	N/A	

Good Practice and Requirements

Good Practice

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.
FDNMed1.1a	KGH MAU had a high number of locum consultants with limited UK experience. In addition, the trainees reported that there	The Trust is required to confirm through schedule and job plan, that all patients in	R1.12

	was poor clinical supervision and there was no daily consultant led ward round.	MAU receive a consultant led ward round every day including weekends. Please provide required evidence by 01 March 2020.	
FDNMe d1.1b	The review team heard of a Plus One and Plus Two Policy and of subsequent patient safety concerns raised in relation to the regular misapplication of the policy.	Trust is required to undertake a daily report of all plus one / plus two patients as a Datix and produce a weekly/ monthly report of adherence to policy and safety concerns. Please provide required evidence by 01 March 2020.	R1.2
FDNMe d1.4a	The review team heard that the foundation year one (FY1) trainees had been left unsupervised on wards at weekends.	The Trust is required via the Rota Oversight Committee to have a weekly rota forecasting meeting. This must be chaired by the consultant lead, rota coordinator and higher trainee with rota oversight responsibility. This meeting should proactively review the rota of the week, assess seniority and cover for each clinical area and ensure that no clinical area is left with inadequate / lack of middle grade cover. This will also include all week and weekend days. Please provide required evidence by 01 March 2020.	R1.2
FDNMe d1.4b	The review team heard of concerns in relation to clinical supervision in gastroenterology. Trainees cited limited access to senior clinical advice and support throughout the day which the review team could be stressful.	The Trust is required to ensure that there is adequate staffing for the workload and that onsite middle grade support is provided on the ward to Foundation doctors on all days. Please provide required evidence by 01 March 2020.	R1.12
FDNMe d1.5	The review team heard of ongoing issues with the Medical Staffing Co-ordinators which the trainees felt had impacted upon their working relationships.	The Trust must ensure all correspondence with Medical Staffing Co-ordinators must be copied to the Consultant and ST3+ trainee lead for the rota. Any queries or discrepancies should be resolved through the Rota Forecasting Meeting and be a regular feature in the Medical LFG. Please provide required evidence by 01 March 2020.	R1.12
FDNMe d1.6	The review team heard of a lack of local induction and access to Trust systems for locum doctors across all areas of medicine.	The Trust is required to immediately introduce a brief induction pack for all locum doctors on their arrival to the Trust. This must include access to all the clinical systems required for providing safe and effective care. In other Trusts this is provided by a departmental manager combined with an electronic induction pack. No locum doctor should be expected to be on duty without completing this induction. Please provide required evidence by 01 March 2020.	R1.13
FDNMe d1.7	The review team heard that the Elderly Response Unit (ERU) Consultant was not present at the daily morning handover meeting.	The Trust is required to send HEE a confirmed standard operating procedure for MAU ward rounds which states clearly attendance of ERU and MAU consultants and a process for all patients to be handed	R1.14

		over to the morning team. This should clarify the handover documentation, audit of attendance and a schedule of quarterly audit of effectiveness. Please provide required evidence by 01 March 2020.	
FDNMed 2.1	The review team heard that the IR1 reporting system has been used negatively between different staff groups and towards the foundation trainees. This had resulted, at times, in the trainees being pressurised to change their clinical decisions to effect patient discharges.	The Trust is required to ensure that there is a daily multi-professional 'huddle/ Board round' in all clinical areas. There should be a rolling program of multi-professional learning using in-situ simulation and team behaviour assessment (tool) as part of organisational development on a quarterly basis. Please provide required evidence by 01 March 2020.	R1.17
FDNMed 2.4a	The review team heard that the trainees were unaware of the Deteriorating Patient Pathway and of how to escalate via the Outreach Team.	Outreach Team have a dedicated training session in every doctor's induction and the deteriorating patient is covered in teaching sessions. Medical Education Team to review the teaching programmes, and to circulate the Deteriorating Patient protocol to all trainees. This will also be uploaded to the Medical Education App once the App is live (expected end of January 2020). Please provide required evidence by 01 March 2020.	R1.2
FDNMed 2.4b	The review team heard that greater clarity was required for trainees on who the on-call consultants were and how they could be contacted (DECT numbers etc).	The Trust to ensure transparency of clinical on-call teams is clearly available to all trainees within medicine. This information must be clearly displayed in the MAU Handover Room; and it is the responsibility of the Speciality Manager to ensure it is updated daily. Please provide required evidence by 01 March 2020.	R1.2
FDNMed 3.2	The review team heard that trainees had been met with hostility from Radiology Teams when requesting investigations / results.	The Trust is required to arrange a 'relationship meeting' with Radiology department in discussing the feedback reports of intimidation and development of a charter of professional discussions. Please provide required evidence by 01 March 2020.	

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.

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.**

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty, Deputy Postgraduate Dean, HEE London (north central and east London)
Date:	06 February 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. An initial response will be due within two weeks of receipt of this summary report.