NHS
Health Education England

Guy's & St Thomas' NHS Foundation Trust

Renal Medicine

Risk-based Review (on-site visit)

Quality Review report

25 February 2020

Final Report

Developing people for health and healthcare

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Quality Review details

Training programme / learner group reviewed	Renal medicine at Guy's Hospital (Guy's)
Number of learners and educators from each training programme	The review team met with: • four previous and current renal medicine higher trainees; and • seven educational and clinical supervisors (ESs and CSs) based in renal medicine. The review team also met with the following Trust representatives: • Medical Director • Director of Medical Education • Associate Director of Education, Training & Development • General Manager for Transplant, Renal & Urology Directorate • Medical Education Managers • Guardian of Safe Working Hours • Project Support Officer for Guardian of Safe Working Hours • Clinical and educational leads and consultants

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 renal medicine at Guy's. Renal medicine at Guy's received five red outliers and eight pink outlier results on the GMC NTS for 2019. The red outliers related to overall satisfaction, supportive environment, local teaching, study leave and rota design. The pink outliers related to clinical supervision, handover, induction, adequate experience, curriculum coverage, educational governance, educational supervision and feedback.
Supporting evidence provided by the Trust	The review team did not receive any supporting evidence from the Trust in advance of the on-site visit. However, minutes from feedback meetings held with renal medicine trainees in November 2019 were shared with Health Education England (HEE) as part of the Trust's action plans relating to the GMC NTS 2019 red outlier results.

Summary of findings	The quality review team would like to thank the Trust for accommodating the on-site visit and for ensuring that all sessions were well attended. The review team was pleased to note several areas that were working well: • The higher trainees felt there had been a proactive and prompt response to the renal medicine team's GMC NTS results for 2019. This included improvements to the rota and to scheduling, recruitment of additional medical and other posts, such as physician associates (PAs). These changes had a very positive impact on their experience. • All the renal medicine consultants were praised by the higher trainees for the way they prioritised the experience of trainees within the department.

	• All the higher trainees said they would recommend their training posts to colleagues and the service to their family and friends. • Aspects of their training experience that were particularly commended by the higher trainees were: induction to the post; responsiveness of management to leave requests; and very prompt access to senior support for unwell patients, queries in clinic and assistance with procedures. • Teaching was felt to be of high quality and multi-disciplinary meetings (MDMs) of good educational value. HEE also identified the following areas for improvement, which were verbally outlined to the Trust at the visit and shared in writing the following day: • The review team noted there had been significant improvements to the working environment on the renal medicine and surgical transplant wards, with a clear plan that included the recruitment of three PAs and forthcoming recruitment to a total of three ward-based surgical junior doctors. Workload on the wards should be monitored during this time to ensure a constant, adequate surgical junior doctor presence. • The review team heard that external referrals were not systematically documented or handed over, which led on occasions to delays of transfer. The trainees did not feel these had an impact on patient safety. • The review team heard that the higher trainees would welcome the opportunity to lead ward rounds on both the renal medicine and surgical transplant wards, with an appropriate amount of supervision, depending on seniority and experience, in order to gain more independence during their training. • The review team heard that the higher trainees felt there were missed educational opportunities working on the surgical transplant ward. • The review team heard that the higher trainees found it difficult to make the most of the large number of specialist clinics available at the Trust, due to rota and workload.

Quality Review Team			
HEE Review Lead	Jo Szram Deputy Postgraduate Dean Health Education England, South London	**Training Programme Director**	Megan Griffith Training Programme Director North West London
Head of School Representative	Andrew Deaner Head of School for Medicine Health Education England, London	**Trainee/Learner Representative**	Rupert Bright Trainee Representative
Lay Member	Sadhana Patel Lay Representative	**HEE Representative**	Gemma Berry Learning Environment Quality Coordinator Health Education England, South London
Educational overview and progress since last visit – summary of Trust presentation			

The educational lead for renal medicine at Guy's opened the review by acknowledging that the team was already aware of some of the key issues raised through the GMC NTS 2019 before the survey was opened and the results were released (survey opened March 2019 and results released end of June 2019). They said they had tried to address these issues in advance of the survey going live but expected the results to be negatively outlying for certain indicators, such as rota design.

The review team heard that the previous cohort of trainees had experienced difficulties with the rota prior to completing the NTS in 2019, partly due to a change in rota management processes and personnel, and partly due to rota gaps. The review team was advised that the renal medicine team normally had a total of 10 higher trainees and Locally Employed Doctors (LEDs) in post for the rota, but during 2018/19 there were only seven. Furthermore, a trainee requiring additional support (TRAS) had to be taken off the rota, which had created an additional rota gap for a period of time, although they were reinstated at a later point. Whilst the renal medicine consultants had tried to cover the rota gaps, the educational lead recognised there had been a lack of continuity and structure in doing so. They also recognised that these rota gaps had put additional workload pressure on the previous cohort of trainees.

The review team heard that rota management had been transferred to a non-clinical management team prior to the launch of the NTS in 2019, but implementation issues continued for some time, causing disruption to the team. The educational lead said that the renal medicine team had since taken over control of the rota again and from March 2019, the educational lead and supervisors had prioritised making the rota more bespoke to each of the trainees' learning needs, whilst ensuring there was equity of opportunity and workload between them. The educational lead added that on review of these new rota arrangements at the end of the previous training year, all the higher trainees had received equitable learning opportunities and consistent clinical exposure across each area of renal medicine, including the renal transplant ward. The review team heard that the current trainees were keen and encouraged to input into rota design in the future, to give them more control over their learning.

The educational lead confirmed that the current on-call rota for renal medicine was one in 10. However, as there were only eight higher trainees and equivalent-level LEDs in the renal medicine team at present, on-call rota gaps were filled by the team's full-time research clinical fellows (of which there were four). Since the rota was returned to the management of the renal medicine team, the educational lead said that these on-call rota gaps were filled further in advance than previously, when arrangements were often made at late notice. The review team heard that on-call night shifts were resident.

The review team heard that although there were now eight higher trainees and equivalent-level LEDs in post, if some were on leave, on nights or on zero days, the renal medicine team was still only operating with approximately five higher trainees and LEDs rostered on shift in-hours at any one time, which could be challenging. The educational lead said that generally, one would cover the renal transplant ward, one would cover the renal medicine ward, one would cover the St Thomas' Hospital (St Thomas') site, one would cover procedures and one would cover the Rapid Assessment Unit (RAU) and external referrals on a rotational basis. However, the educational lead advised that the latter role (RAU and referrals) was being reviewed, as the workload could be unmanageable at times.

Whilst the rota and workload were generally considered by the renal medicine team to be better for the current cohort of trainees than those previously, the educational lead recognised the need for flexibility within the rota to effectively manage gaps and ensure workload was not too intense for those on shift. They acknowledged that some trainees in previous cohorts had not had the opportunity to perform certain procedures due to the rota and workload, and their expectations of their posts and duties had not always been managed by the consultants effectively. To address these concerns, the review team heard that three physician associates (PAs) had recently been recruited to the renal medicine team, who had helped to ease the workload burden on trainees, allowing them to focus on more educational tasks and opportunities. Furthermore, the review team heard that job plans had been updated for each of the trainees' rotations within renal medicine, to better manage their expectations. Within these job plans, the educational lead said that trainees were given an outline of their clinical and ward duties, and were allocated more time with their supervisors on a one-to-one basis, more opportunities to work on dialysis cases (which was lacking previously) and plans were in place to review the trainees' exposure to procedures.

The review team heard that from April 2019, the renal medicine supervisors had aimed to sign off 75 per cent of newly-inducted trainees' workplace-based assessments within their first eight weeks in post, but they had managed to sign off 100 per cent of the trainees within this timeframe. The educational lead said that, to achieve this, clinics had been rearranged for the first two weeks to ensure consultants were more readily available to supervise procedures. The educational lead reported that they thought that the renal medicine supervisors actively encouraged trainees to seek new learning opportunities, including attending clinics on a supernumerary

basis if they wanted to. Furthermore, by August 2020 the educational lead said the team would have the full complement of 10 higher trainees and LEDs in post, which would allow trainees to utilise the full potential of the learning opportunities available in the renal team.

The review team heard that the renal medicine consultants were surprised to receive a red outlier result for study leave in the GMC NTS 2019, as this had not been an issue for the team historically. The educational lead said that on average, trainees took three weeks of study leave throughout the training year and all study leave requests had been granted for the previous cohort. The team's research clinical fellows were asked to cover the trainees' shifts during their study leave, although trainees were usually required to swap any on-call shifts instead. On speaking with the previous cohort of trainees following the GMC NTS 2019, the educational lead said that some had had to submit leave requests more than once, as they did not receive a response in a timely manner. The educational lead said these delays were partly due to the rota gaps at the time, as the supervisors had to ensure the service could be covered, but that reassurances were given to the trainees that their requests would be approved. The review team heard that study leave did not include mandatory teaching sessions, as these were already accounted for in the trainees' timetables.

The educational lead confirmed that local teaching sessions were held every Thursday, designed around the renal medicine curriculum, and although these were predominantly consultant-led, each higher trainee was asked to lead at least one session during their post. In addition to these teaching sessions, the review team heard that trainees had the opportunity to attend departmental academic meetings, histopathology meetings, complex transplant and joint haematology MDMs, workstream meetings, and more. The educational lead said that weekly teaching sessions were duplicated to ensure trainees who were initially unable to attend (due to rota arrangements or leave) did not miss out. However, they suggested that the previous cohort of trainees may have perceived there was a lack of local teaching because these sessions and meetings did not used to be planned into the rota. The educational lead thought this perception may have had a bearing on the team's GMC NTS 2019 results relating to local teaching.

To address this issue, the review team heard that before the current trainees started in post, they received a teaching plan for the year ahead with confirmed teaching sessions for the first term. This plan aimed to demonstrate that the teaching sessions would cover the breadth of the training curriculum. The educational lead said that for the current cohort, only one teaching session had not taken place due to emergency clinical commitments on the part of the leading consultant. The educational lead acknowledged that whilst the other meetings outlined above offered good educational opportunities, these were sometimes held at lunchtimes or when trainees were busy working on wards, so they were not always able to attend. However, they felt that the current rota offered more flexibility for trainees to be able to partake than previously. The review team was told that whilst documentation at MDMs tended to be consultant-led, if a higher trainee was aware of the patient being discussed, they could present the case or input into discussions. This was encouraged by the team, but not all trainees wanted to do this.

The educational lead advised that the team's research clinical fellows covered the higher trainees' shifts to allow them to attend regional teaching sessions. Higher trainees were also prioritised to attend the Peritoneal Dialysis Academy training day and simulation day, if they wanted to go. The review team heard that the previous and current cohort of trainees had shared positive feedback on their teaching with the educational lead.

Whilst the educational lead did not feel induction had been an issue for renal medicine trainees in the past, they acknowledged there had been a deterioration in the GMC NTS results for this area since 2018. The review team heard that the renal medicine supervisors used these results as an opportunity to revise the induction process. The current cohort of higher trainees received a tour of the unit (which had not taken place for the previous two cohorts) and a 'meet and greet' session on commencing in post, and were allocated time after the initial induction programme to digest the information they had received and to ask any questions. Exception reporting was also said to have been covered during induction and all trainees were sent both a Trust induction pack and a departmental induction pack, which included information about the team and rotas.

The review team heard that the educational lead promoted an open-door policy for trainees if they needed support from their supervisors. They confirmed that weekly feedback sessions with trainees had now been incorporated into the local renal medicine training programme, which allowed trainees more opportunities to discuss career aspirations, amongst other topics. The review team was told there was now a greater emphasis amongst the supervisors to share feedback with trainees in real-time, such as during their ward duties, and to respond to feedback from trainees in a timelier manner. As mentioned above, more one-to-one supervisor-trainee sessions had also been incorporated into trainees' job plans to improve feedback processes.

With regards to educational governance, the review team heard that over the past year, the team had held trainee feedback forums, meetings with the Director of Medical Education (DME) and Guardian Of Safe Working

Hours (GOSWH), bi-monthly renal medicine consultant meetings (with two trainee representatives in attendance) and monthly meetings between the renal medicine and surgical transplant consultants. The review team recommended more formal educational governance structures were established within and between these two teams, with greater trainee involvement, and that regular meetings were arranged to bring all supervisors and their trainees (of all grades) together. The DME confirmed that this would be addressed through a quality improvement project in the year ahead.

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
RM1.1	**Patient safety** The higher trainees in renal medicine said they sometimes found it difficult to get surgical colleagues to assess patients on the Patience (renal medicine) ward which, depending on when the patient was admitted, could lead to delayed discharges. They explained there was a dedicated consultant available on a Monday to conduct vascular assessments, but if a patient was admitted later in the week, they may not be seen till the following Monday. The trainees thought the renal medicine consultants were likely to be aware of this issue.	Yes, please see RM2.2
RM1.2	**Appropriate level of clinical supervision** The higher trainees thought their named clinical supervisors (CSs) in renal medicine were approachable and helpful. The higher trainees felt that the clinical supervision and support they received from consultants whilst working on Patience ward (renal medicine) was of an appropriate level. However, the trainees said they would have liked more autonomy and independence whilst working on Richard Bright ward (renal transplant surgery). The higher trainees told the review team they generally felt comfortable approaching on-call consultants for advice and were able to access support out of hours and at weekends. The review team heard that the surgical transplant team readily shared information about unwell renal transplant patients with the renal medicine trainees.	Yes, please see RM1.6b

RM1.3	**Rotas** The review team heard that renal medicine higher trainees and locally employed doctors (LEDs) were required to cover each of the following areas at all times: Rapid Assessment Unit (RAU) (including handling external referrals); Richard Bright ward (renal transplant surgery); Patience ward (renal medicine); procedures; and, renal cases at the St Thomas' Hospital (St Thomas') site. The renal medicine trainees rotated through each of these areas during their training programme. The higher trainees acknowledged that delivery of these service requirements with rota gaps had put pressure on members of the renal medicine team in the past, but since additional staff were recruited, working conditions and the culture within the team had improved overall. The educational supervisors (ESs) and CSs reiterated this view and specifically acknowledged how helpful and crucial the recruitment of physician associates (PAs) had been to the functionality and workload of the team. The review team heard the team had initially planned to recruit two PAs but decided to recruit a third following positive feedback from colleagues. The ESs and CSs confirmed that the renal medicine team currently had two research clinical fellows as locally employed doctors (LEDs) working on quality improvement projects and clinical duties at a ratio of 70:30 and 50:50 respectively. The 50:50 ratio was determined to be necessary to offer more support to the team with service delivery. The renal medicine team had four clinical research fellows who helped to cover the on-call rota. The ESs and CSs advised there were six to eight doctors on the on-call rota at any one time. The review team heard from the higher trainees that, depending on their rotation, they sometimes worked beyond their rostered hours, but they did not feel this was excessive and they had not yet submitted any exception reports for additional time worked. They said these situations tended to occur when they were performing procedures, when they would perhaps leave work at 17:45 instead of 17:00. Whilst working on the Richard Bright ward (renal transplant surgery), the higher trainees said they spent a significant amount of time going between transplant clinics, radiology (requesting scans) and reviewing of patients, so they felt the core medical trainee (CMT) and PA also rostered to cover the ward were vital for delivering continuity of care and escalating issues to the higher trainees and LEDs where necessary. However, the higher trainees highlighted that Mondays could be challenging, as the CMT attended teaching that day and sometimes only the PA was left covering the ward. Although prescribing pharmacists were also based on the ward, they were often in clinic. This meant that the rostered renal medicine higher trainee or LED occasionally had to cover the CMT's duties. The review team was informed that the higher trainees found the St Thomas' rotations (one-week blocks) educationally useful and interesting, as they had the opportunity to review new referrals, acute patients and patients on dialysis. However, they said the workload on this rotation was variable, which had been raised as an issue in the past. Some members of the renal medicine team had reportedly differing views on whether trainees and LEDs should be based at the St Thomas' site during the rotation, or whether they could deal with queries by phone (as they would when liaising with other district general hospitals). Staff at St Thomas' were also said to prefer and expect on-site support from the renal medicine team. The trainees confirmed that they based themselves at St Thomas' site during these rotations but if their workload was light, they helped with cases at Guy's Hospital (Guy's). The higher trainees confirmed that they were rostered to attend general outpatient clinics and felt they saw an adequate number of patients. However, they were not rostered to attend any of the team's specialist clinics, which included vasculitis, lupus, dialysis, sickle cell and renal transplant work-up. The trainees said they proactively arranged to attend some of these clinics on a supernumerary basis when they had the time, but this was not always possible. The trainees were keen for the specialist clinics to be formally timetabled in their training programme, as they felt they were educationally useful and allowed them to meet their curriculum requirements (particularly as such specialist learning opportunities were not necessarily available elsewhere). The review team	Yes, please see RM1.3

	agreed it was important for the trainees to make the most of these learning opportunities whilst at Guy's. Whilst the ESs and CSs believed the general outpatient clinics offered good training, they acknowledged that rota gaps and staff shortages in the team had negatively impacted upon trainees' opportunities to attend specialist clinics. The ESs and CSs said they were keen to address this issue. In doing so, they thought finding extra clinic space could be a challenge to overcome, and a significant amount of work would be required to schedule the specialist clinics in the higher trainees' timetables. However, they thought this would be more achievable later in the year when staffing levels were due to increase. The review team also heard that not all of the specialty clinics were held on a regular basis. The higher trainees advised that they sometimes dealt with clinical correspondence from outpatient clinics during night shifts if time allowed, but they also had time to dictate clinic letters during the day.	
RM1.4	**Induction** The higher trainees told the review team that they received a satisfactory corporate Trust induction on commencing in post at Guy's. They were asked to complete online learning modules before they were given access to the Trust's IT systems. They were also provided with useful contact lists and necessary identification in a timely manner. The review team heard that the trainees received one main local induction on joining the renal medicine team, but no subsequent inductions for each rotation. They felt this induction process worked well. None of the trainees were rostered to work on-call as soon as they had started in post; only when they were comfortable to do so.	
RM1.5	**Handover** The higher trainees confirmed that weekday morning handover meetings were held at 08:30, except Mondays when they began at 08:15. Handover tended to last for 10 minutes per ward, with the renal team assessing every inpatient in turn. On Fridays, a more detailed handover was conducted from 16:30 – 18:00 in preparation for the weekend. At weekends, handover meetings were held at 16:30. The same renal medicine doctor was on shift from Friday to Sunday for continuity of care. The trainees said that whilst consultants rarely joined weekday handover, they joined Monday handover on a more regular basis and always on a weekend. Handover tended to be conducted by higher trainees and equivalent-level LEDs, with consultant input when available. There was no senior nurse presence at handover. The review team heard that although handover meetings were formally timetabled and attendee requirements were clear, the format was quite unstructured, with no assigned chair to lead discussions. As a result, the higher trainees said that important clinical information had been missed on occasion, and results were not always readily available for discussion at handover or followed-up appropriately. Whilst the renal medicine team at Guy's did not have an acute take, the higher trainees confirmed that they accepted renal patients from district general hospitals and some from St Thomas' (which did have an acute take). However, the review team was informed that there was no centralised system for keeping track of external referral patients admitted to the renal wards, which led to delays in patient care, such as delayed transfers or duplicate conversations between staff and patients. The ESs and CSs recognised that handover processes on the renal wards could be improved and they confirmed they were working with IT to implement a new handover platform which included a data form for referrals.	Yes, please see RM1.5
RM1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience**	

	Whilst working on the Richard Bright (renal transplant surgery) ward, the higher trainees said they would have liked more autonomy, decision-making responsibilities and opportunities to lead ward rounds, which tended to be led by surgical colleagues instead (even though the trainees did not feel surgical input was required for all of the patients on the ward). The trainees said decisions about patient care on the Richard Bright ward tended to be made by consultant transplant surgeons and only they and the surgical trainees had access to EOS, the online transplant system. The higher trainees advised that there were no standardised processes in place between the transplant surgeons and renal medicine trainees in terms of discussing organ offers. They said their involvement with organ offers at present was dependent upon surgeons sharing information with them on a more informal, ad hoc basis. The review team heard that the higher trainees had spoken with their educational lead about their desire to become more involved with organ offers and had been told they would have the chance to work more closely with the transplant coordinator later in the year, when the team was better staffed. The ESs and CSs confirmed plans for renal medicine trainees to spend one week shadowing transplant coordinators as part of their training programme. The ESs and CSs confirmed that they were working with the educational lead for transplant surgery to incorporate joint surgical and renal medicine teaching sessions into the trainees' timetables, which they hoped would, in turn, foster more effective joint working across the wider renal team. The ES and CSs also confirmed that the renal medicine trainees would become more involved in organ offers in the future. The ESs and CSs acknowledged that renal medicine higher trainees missed out on learning opportunities on the Richard Bright ward and they had been reflecting on ways to address this issue, including how to offer the trainees more autonomy. The review team heard that the ESs and CSs felt able to have discussions with the transplant surgeons about this.	Yes, please see RM1.6a & RM1.6b Yes, please see RM1.6b
RM1.7	**Protected time for learning and organised educational sessions** The higher trainees told the review team that they received regular, good quality local teaching. They confirmed that they were generally able to attend multi-disciplinary meetings (MDMs) and other meetings that were educationally useful. The trainees said they had the opportunity to prepare slides, present patients and lead discussions at these meetings. The higher trainees felt that they received good quality regional teaching.	

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.

RM2.1	**Effective, transparent and clearly understood educational governance systems and processes** The higher trainees recognised that the renal medicine consultants had listened to feedback from the previous cohort of trainees and taken proactive measures to address	

	the issues raised. The trainees felt the learning environment had improved as a result. The trainees felt very well supported by all the renal medicine consultants. The review team heard that the educational lead was standing down from this role in the near future. The ESs and CSs advised that the Trust was establishing a Trust board for PAs, to improve their learning opportunities.	
RM2.2	**Impact of service design on learners** The higher trainees stated that some surgical transplant patients arrived on Patience ward (renal medicine) unexpectedly without any prior notification from the surgical transplant team. The trainees said they were usually able to manage these cases using a formalised pathway and by liaising with surgical higher trainees, but the situation could be challenging. The review team heard that surgical trainees tended to spend more time in theatres than they spent on surgical tasks on the wards. However, the higher trainees felt improvements had been made in this regard over the past two months with the recruitment of a ward-based surgical trainee at specialty training level one (ST1), who provided the renal medicine trainees with additional support for surgical cases. They thought it would be useful to have more surgical junior trainees or LEDs based on the renal wards who could clerk transplant patients. The ESs and CSs confirmed that two additional ward-based surgical junior LEDs were to be recruited from August 2020, supervised by the consultant transplant surgeons. The ESs and CSs said they had discussed the role of the surgical junior doctors with the transplant surgeons and emphasised that there should always be a surgical junior doctor presence on the wards to support the renal medicine trainees. They also thought that the surgical junior doctor would alleviate the CMTs and internal medicine trainees (IMTs) based in renal medicine of some of their ward duties to allow them to cover other areas and tasks.	Yes, please see RM2.2
RM2.3	**Systems and processes to make sure learners have appropriate supervision** The higher trainees expressed the view that some of the surgical transplant consultants did not consider themselves responsible for renal medicine trainees' clinical supervision or education, even though they worked closely with one another as part of the wider renal team. The trainees felt they missed out on learning opportunities, such as organ offers and procedures, as a result of this. The trainees felt it would be beneficial for the transplant surgeons to be more formally linked to renal medicine trainees in the supervision structure.	Yes, please see RM1.6b
RM2.4	**Organisation to ensure access to a named clinical supervisor** The review team heard that the higher trainees had named clinical supervisors in renal medicine, who they said offered support during outpatient clinics and procedures.	
RM2.5	**Organisation to ensure access to a named educational supervisor** All the higher trainees confirmed that they had met with their named ESs. However, one of the trainees had only met their ES for the first time in December rather than October, which was later than they would have liked. They said they had raised this concern with the educational lead. The ESs said they generally had time to meet with their trainees on a regular basis, but pre-planning was crucial; ad hoc meetings were said to be more difficult to coordinate.	
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.**		
RM3.1	**Behaviour that undermines professional confidence, performance or self-esteem** None of the higher trainees reported experiencing any negative interactions with colleagues.	
RM3.2	**Access to study leave** The higher trainees told the review team that study leave and annual leave requests were approved promptly and this process was straightforward.	

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.**		
RM4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The ESs (who were also CSs) confirmed they had 0.25 programme activity (PA) in their job plans for their supervisory duties (the educational lead had 0.75PA). The ESs confirmed they each provided educational supervision to one or two trainees. The supervisors felt the Trust was proactively supportive of ESs. The review team heard that the Trust held regular ES support groups, Trust-funded training courses including how to support trainees requiring additional support (TRAS) and there was a revalidation structure in the ES appraisal system.	

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.**		
RM5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The higher trainees told the review team that some trainees in previous cohorts had experienced difficulties getting procedures signed off to meet their curriculum requirements, but they felt this process had improved and they had not had any issues in this regard.	

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.**		
RM6.1	**Learner retention** The review team was pleased to hear that all the higher trainees would recommend their training posts to colleagues and the renal medicine service to their friends and family. The trainees said they enjoyed training in the renal medicine team at Guy's.	

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.
RM2.2	From August 2020 (on the recruitment of two additional surgical junior doctors), workload on the renal wards at Guy's Hospital (Guy's) should be monitored to ensure a constant, adequate surgical junior doctor presence.	Health Education England (HEE) requires the Trust to obtain feedback from higher trainees in renal medicine regarding workload and surgical junior doctor presence on the renal wards. Please submit this evidence by 1 September 2020, in line with HEE's action plan timeline.	R2.3
RM1.5	External referrals should be systematically documented and handed over to avoid	Please provide a copy of a formal, documented handover process for external	R1.14

	delayed transfers. HEE requires the Trust to provide evidence of a more formalised handover system in the renal medicine team at Guy's, with higher trainee feedback to ensure that the implemented solution is acceptable.	referrals to the renal medicine team, and feedback from higher trainees on this process. Please submit this evidence by 1 September 2020, in line with HEE's action plan timeline.	
RM1.6a	Higher trainees in renal medicine should have the opportunity to lead ward rounds on the renal medicine and surgical transplant wards at Guy's, with an appropriate amount of supervision, depending on seniority and experience, in order to gain more independence during their training. HEE requires feedback from higher trainees to ensure this becomes a regular part of their ward activity.	Please provide feedback from higher trainees in renal medicine regarding ward rounds on the renal medicine and surgical transplant wards. Please submit this evidence by 1 September 2020, in line with HEE's action plan timeline.	R5.9
RM1.6b	As higher trainees in renal medicine felt there were missed educational opportunities working on the surgical transplant ward at Guy's, HEE requires the Trust to provide evidence of a joint surgical and renal medicine approach to faculty meetings and educational and workplace supervision, feedback and learning events.	Please provide a documented overview of joint educational governance, supervision and training arrangements between the renal medicine and surgical transplant teams. Please submit this evidence by 1 September 2020, in line with HEE's action plan timeline.	R5.9
RM1.3	HEE requires the Trust to provide evidence of scheduling of specialist renal clinics in renal medicine higher trainees' timetables.	Please provide copies of higher trainees' timetables showing time specifically allocated to specialist renal clinics. Please submit this evidence by 1 September 2020, in line with HEE's action plan timeline.	R5.9

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
HEE recommends more formal educational governance structures are established within and between the renal medicine and surgical transplant teams, involving trainees to a greater extent, and that regular meetings were arranged to bring all	Trust

supervisors and their trainees (of all grades) together. The DME confirmed that this would be addressed through a quality improvement project in the year ahead.	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Jo Szram, Deputy Postgraduate Dean, South London
Date:	4 August 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.