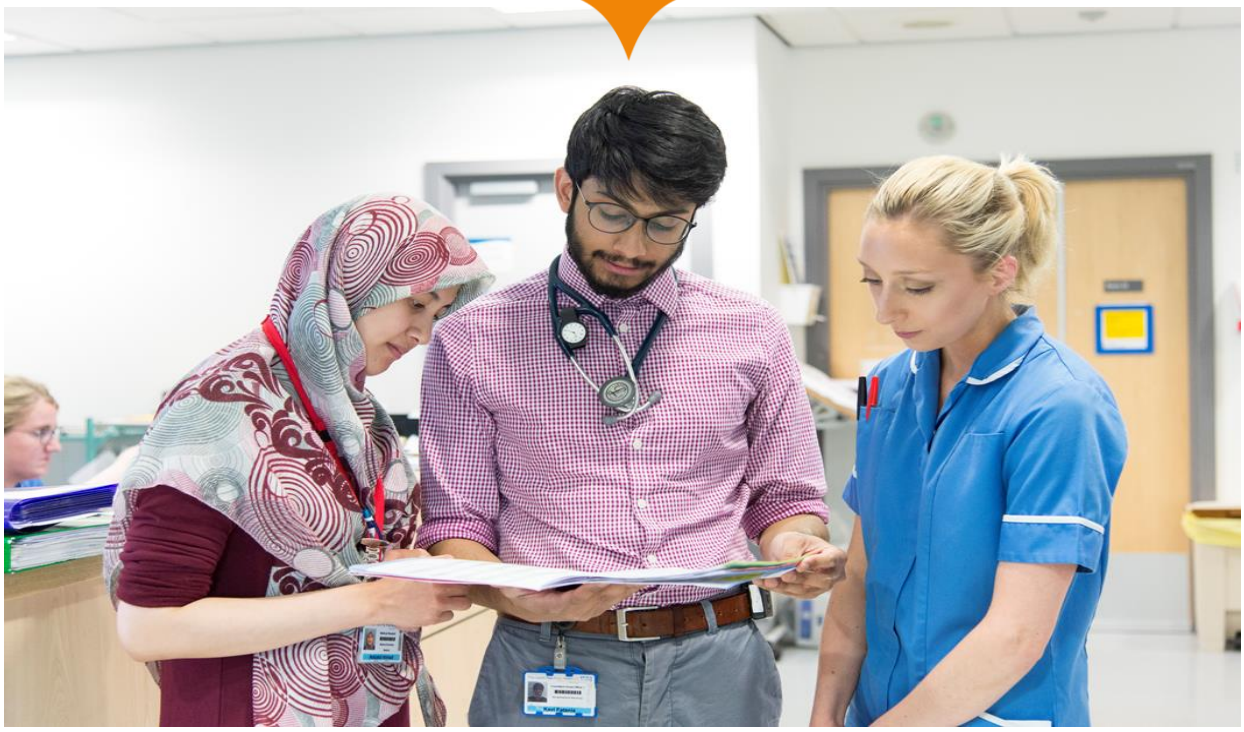
Health Education England

HEE Quality Interventions Review Report

Barking, Havering and Redbridge University Hospitals NHS Trust (Trust-wide)

Acute internal medicine and respiratory medicine

Learner and educator review



London – North East London

Date of review: 11 October 2021

Date report issued to the Trust: 25 November 2021

Version 1

Review Overview

Background to the review:	A learner and educator review of acute internal medicine was agreed at a senior leader engagement visit (SLEV) to the Trust in June 2021. Significant concerns were raised regarding acute internal medicine in 2018 and 2019, and the department was placed in enhanced monitoring by the General Medical Council (GMC). Subsequently, regular SLEVs were undertaken and, while it was apparent that there had been progress in addressing some of the concerns, there was limited access to the views of learners and supervisors. This review was intended to assess the views of learners and educators about the progress made in the department and the sustainability of the changes. Respiratory medicine was added to the scope of the review following a significant deterioration in the GMC National Training Survey (NTS) results for that specialty from 2019 to 2021. The Trust leadership indicated that the senior leadership for respiratory medicine was the same as that for acute internal medicine, and therefore it was proposed to meet with the learners and educators in both specialties.
Subject of the review (e.g. programme, specialty, level of training, healthcare learner group)	Acute internal medicine and respiratory medicine

Who we met with:	Service Manager Director of Medical Education Head of Medical Education and Training Clinical Lead for Acute Internal Medicine College Tutor Associate Director of Medical Education Clinical Lead for Respiratory Medicine Foundation Training Programme Director (Acute Internal Medicine) Foundation Training Programme Director (Respiratory Medicine) Specialty Manager Acute Medicine Associate Director of Chief Medical Office Specialty Manager Respiratory Chief Medical Officer Deputy Chief Medical Officer Workforce Hub Manager Five foundation and GP VTS trainees in acute internal medicine Five foundation trainees in respiratory medicine Six IMT and higher trainees in acute internal medicine Seven IMT and higher trainees in respiratory medicine Five clinical and educational supervisors for acute internal medicine Seven clinical and educational supervisors for respiratory medicine
Evidence utilised:	Local Faculty Group minutes Summary of relevant Datix reports (to include SIs and Never Events) Most recent MEC minutes Details of the number of exception reports/summary of GoSWH Board report Learning from excellence reports Rota including fill rate Breakdown of learner groups within the department Evidence of teaching sessions and attendance lists Evidence of organisation-wide and departmental induction feedback Breakdown of educational and clinical supervisors within the department

Review Panel

Role	Name / Job Title / Role
Quality Review Lead	Louise Schofield Deputy Postgraduate Dean Health Education England (North East London)
Specialty Expert	Catherine Bryant Deputy Head of the London Specialty School of Medicine
Specialty Expert	Keren Davies Foundation School Director (North Central and East London)
Specialty Expert	Jyoti Sood Associate Director, School for General Practice
GMC representative	Lucy Llewellyn Education QA Programme Manager (London) General Medical Council
Lay representative	Anne Sinclair
HEE Quality Representative(s)	Paul Smollen Deputy Head of Quality, Patient Safety and Commissioning Health Education England (London) Louise Brooker Deputy Quality, Patient Safety and Commissioning Manager Health Education England (London) Chloe Snowdon Learning Environment Quality Coordinator Health Education England (North East London) Hazel Minihane Quality, Patient Safety and Commissioning Officer Health Education England (London)

Executive summary

The review panel thanked the Trust for facilitating the review and ensuring good attendance at all sessions.

The acute internal medicine (AIM) trainees told the review team they saw a good variety of cases and had lots of autonomy but the department was very busy, there were a lot of pressures, and the emergency department referral process and criteria needed to be strengthened. The AIM trainees also said that the multiple electronic records systems were incredibly frustrating as there was a different system for everything. The review team heard that some internal medicine training (IMT) trainees had been placed on Covid-19 wards for their six-month placements, without the opportunity to rotate onto another respiratory ward to gain experience of a broader range of cases. The respiratory trainees reported a disconnect between the workforce hub coordinating the rotas and actual staffing on the wards. Trainees in both departments highlighted problems with competency levels of Trust grade and locum doctors and inefficient mechanisms for trainees to feedback on their training and education.

Overall, the trainees in both departments gave positive feedback about their training, particularly the supervision they received and the range of learning experiences available. The review team issued a number of actions relating to the issues requiring improvement which were identified on the day.

Review findings

The findings detailed in the sections below should be referenced to the quality domains and standards set-out towards the end of this template. Specifically, mandatory requirements should be explicitly linked to quality standards. Not all of HEE's domains and standards have been included, only those that have a direct operational impact on the quality of the clinical learning environment, which a quality review will be most likely to identify (although this does not preclude other standards outlined in the Quality Framework being subject to review, comment and requirements where relevant).

Mandatory requirements

Mandatory requirements and Immediate Mandatory Requirements (IMRs) should be identified as set out below. IMRs are likely to require action prior to the draft Quality Review Report being created and forwarded to the placement provider. The report should identify how the IMR has been implemented in the short term and any longer termed plans. Any failure to meet these immediate requirements and the subsequent escalation of actions to be taken should also be recorded if there is a need to.

All mandatory requirements should be detailed in this section. The requirement reference should work chronologically throughout the report and link with the right-hand column in the 'Review Findings' section. Requirements identified should be succinct, SMART and not include the full narrative from the detailed report. Any Requirements should clearly relate to improved achievement of HEE Domain & Standards by the placement provider.

Immediate Mandatory Requirements **Completion of immediate requirements will be recorded below. Subsequent action to embed and sustain any changes may be required and should also be entered below with relevant timescales**		
Requirement Reference number	Review Findings	Required Action, timeline, evidence
	None	
Requirement Reference number	Progress on immediate actions	Required Action, timeline, evidence
	N/A	

Mandatory Requirements The Quality Review Panel will consider which individual or collective findings from the intervention will be added to the Quality Reporting Register, determining the relevant risk score, ISF rating and reflecting the accepted QRR narrative conventions.		
Requirement Reference number	**Review Findings**	**Required Action, timeline, evidence**
ARM1.1	The review team heard that acute internal medicine (AIM) trainees did not think anything would change if they raised concerns and said that after a night shift, they chose to go home rather than stay to complete a Datix form.	Provide evidence that trainees are trained and supported to complete Datix forms and ensure that trainees receive regular feedback on the outcomes of Datixes that are raised. To be completed by 01 March 2022.
ARM1.2a	The review team heard that female trainees in the respiratory medicine department felt they were treated differently to their male colleagues and these behaviours felt undermining. The respiratory medicine trainees also highlighted another example of bullying and undermining in the department.	Provide evidence that the Trust has investigated bullying and undermining behaviours (including relating to sexism) raised at this review. To be completed by 01 March 2022.
ARM1.2b	The review team heard that female trainees in the respiratory medicine department felt they were treated differently to their male colleagues and these behaviours felt undermining. The respiratory medicine trainees also highlighted another example of bullying and undermining in the department.	Share an action plan for how bullying and undermining behaviours (including relating to sexism) are being, and will be, addressed within the respiratory medicine department. To be completed by 01 March 2022.
ARM2.1b	The review team was informed by trainees that the variable competence levels of locally employed doctors meant that trainees had to choose carefully which patients these doctors saw, and this added to trainee workload.	Complete a review of the induction, ongoing teaching and training, and competency support provided to locally employed doctors to ensure that trainee workload is not increased due to having to moderate the work allocation for other doctors. Please provide evidence of this, including trainee

		feedback demonstrating improvement. To be completed by 01 March 2022.
ARM2.1e	The review team heard from trainees that since the workforce hub had started to create rosters, there seemed to be disconnect between the workforce hub's view of staffing on the wards and the reality. The review team heard that this meant annual leave and study leave requests were rejected due to perceived inadequate staffing numbers and this had to be resolved by service managers.	The Trust should complete a review of the functioning of the workforce hub to understand necessary improvements to managing day-to-day ward staffing levels and ensure trainees can book leave. To be completed by 01 March 2022.
ARM2.2	The review team heard that opportunities for trainees to feedback on their training and development, and to see improvements from this feedback, were limited and local faculty groups (LFG) seemed like a 'tick box' exercise.	The review team asked the Trust to review LFG structure and other trainee feedback mechanisms to evidence that trainee concerns are heard and actioned adequately. To be completed by 01 March 2022.
ARM5.1	The review team heard that some internal medicine training (IMT) trainees in the respiratory department had been placed on Covid-19 wards for their six-month placements, without the opportunity to rotate onto another respiratory ward to gain non-Covid-19 experience.	The department should complete a review alongside rota coordinators to enable all IMT trainees to make the most of the learning opportunities available. To be completed by 01 March 2022.

Recommendations

Recommendations are not mandatory but intended to be helpful, and they would not be expected to be included within any requirements for the placement provider in terms of action plans or timeframe. It may however be useful to raise them at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Recommendation	
Related Domain(s) & Standard(s)	**Recommendation**
ARM2.1a	The review team recommends the Trust reviews the rota and training available to acute internal medicine trainees at King George Hospital to ensure that varied learning opportunities including ultrasound training and clinics are available to trainees.
ARM2.1c	The review team recommends the Trust reviews the use of locum and agency staff who are employed very short term in order to reduce reliance of the departments on this type of workforce and thus the impact on trainees.
ARM2.1d	The review team recommends that the FY1 rota is reviewed, and an assessment made of whether FY1s could join the take earlier in the day to enhance their learning opportunities.

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the Quality Review Team, enable the standards within the Quality Framework to be more effectively delivered or help make a difference or improvement to the learning environment being reviewed. Examples of good practice may be worthy of wider dissemination

Learning environment / Prof. group / Dept. / Team	Good practice	Related Domain(s) & Standard(s)
	-	

HEE Quality Standards and Domains for Quality Reviews

Domain 1 - Learning environment and culture
1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive 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 interprofessional learning opportunities.

HEE Standard	HEE Quality Domain 1 - Learning Environment & Culture	Requirement Reference Number
1.1	**Serious incidents and professional duty of candour** <u>Acute internal medicine</u> The review team heard from the acute internal medicine (AIM) trainees that they had not incident reported any patient safety issues but said that management at the Trust was well aware of the general patient experience issues in the Trust. The AIM trainees said they did not have any faith that anything would change if they did raise concerns. The AIM trainees also said that when there were occasions during a night shift that they should report patient safety concerns (which typically related to inappropriate or insufficiently detailed referrals), they did not have time to complete a Datix form and by the end of their shift, wanted to go home instead. <u>Respiratory medicine</u> The foundation trainees confirmed that if they had any serious patient safety concerns, they would raise this with the consultant and would feel comfortable doing this.	ARM1.1

1.2	**Bullying and undermining** <u>Acute internal medicine</u> The trainees in AIM did not think they had experienced or witnessed any bullying or undermining behaviour. The foundation trainees told the review team that when they made mistakes, these were seen as teaching opportunities and they felt they had the freedom to learn from errors because supervisors ensured good patient care was maintained. <u>Respiratory medicine</u> Some of the trainees in respiratory medicine said that they had not experienced any bullying or undermining behaviours in the department. The foundation trainees told the review team that there was a very subtle culture of sexism in the department where doctors sometimes spoke to female trainees in a way which they would not speak to male colleagues. The foundation trainees said they experienced this particularly from longer-term locum doctors and clinical fellows, and not from other doctors in training. The foundation trainees explained these behaviours felt undermining. The internal medicine training (IMT) and higher trainees said female doctors in the department felt they were treated differently to their male colleagues and noted an uncomfortable and upsetting experience when a consultant had held their hand up to a trainee's face to silence a trainee who was speaking. The IMT and higher trainees said that female colleagues did not feel valued in the department as they would elsewhere. The review team heard that all of the 12 consultants in the department were male. The IMT and higher trainees said that some consultants who had tried to raise these issues had received a lot of resistance from others in the department. The IMT and higher trainees noted another example where a trainee had felt bullied and explained that when some consultants acted aggressively in front of other consultants, their colleagues had not challenged that behaviour. The IMT and higher trainees said these sorts of behaviours affected the culture in the department. The review team heard that the Royal College of Physicians Tutor was aware of the situations which had occurred in recent months. The IMT and higher trainees said that there seemed to be a difference between the two hospital sites, with trainees finding consultants at Queen's Hospital more supportive than at King George Hospital. The educational supervisors (ESs) and clinical supervisors (CSs) said they expected trainees to have a good experience in the department and as a team, did not tolerate bullying or undermining behaviours. The supervisors said the Trust had a zero-tolerance policy for bullying and undermining. The review team heard that there was an ongoing formal investigation looking at the experience of one trainee in the department.	ARM1.2a ARM1.2b
1.3	**Quality Improvement** <u>Acute internal medicine</u> The foundation trainees said they thought that the consultants would be supportive if they wanted to do a quality improvement (QI) project. <u>Respiratory medicine</u> The foundation trainees said that if they asked to do a QI project, the consultants would help with this.	

1.4	**Appropriate levels of Clinical Supervision** <u>Acute internal medicine</u> The foundation trainees said that the consultants were very approachable and if they needed support, they were able to ask them for help. The ESs and CSs told the review team that there was a dedicated post take consultant on weekdays as well as at least two junior doctors (and more allocated as needed). The supervisors explained that two consultants were on the weekend post take on call and this meant junior doctors were never left unsupported. The DME said that the Trust provided four different communication routes to trainees about who the consultant on call was at night but that there still seemed to be some confusion among trainees. It was agreed that if it was still an issue, the Trust would have to rework how this was communicated. The review team heard that the AIM consultant body had gone from four to 10 substantive consultants, with two recently appointed. The ESs and CSs said that the department had two long-term locum consultants. The supervisors said that some of the consultants were dual appointments with other specialities which made the department more appealing to trainees and clinical fellows. <u>Respiratory medicine</u> The foundation trainees told the review team that the teams they worked in were nice, consultants were willing to teach, and they felt they had learnt a lot. The foundation trainees said that consultants were approachable and they felt they could raise concerns to them. The foundation trainees said there was a consultant led ward round every day and the department used the 'consultant of the week' model. The foundation trainees explained the consultants provided teaching throughout the day, but some said that it depended on the consultant whether there was teaching during the ward round; some were very keen to teach while others completed ward rounds more quickly. The foundation trainees said that there was less to learn on the Covid-19 ward as there was little variation in treatment plans for these patients. The foundation trainees said they felt well supported by the middle grade doctors on the wards. The foundation trainees said they had middle grade doctor support when looking after patients and if someone was not available, it was quite easy to locate a consultant in a nearby clinic. However, the review team heard of an instance when a foundation trainee was not well supported by more senior doctors in the department while managing multiple sick patients. The review team heard that the trainee felt out of their depth and had asked for input but the middle grade doctor was distracted by taking calls and did not make any decisions regarding the cases the trainee required help with. The review team heard that the trainee had to ask an Emergency Department (ED) doctor for help and found the situation very stressful. The review team heard that at the end of the day, the registrar had done a good summary. The foundation trainees said there were always two middle grade doctors on shift but some of the foundation trainees said they felt the quality of these doctors varied, with the doctors in training better than those not in training. However, some foundation trainees said they felt all of the middle grade doctors were supportive and had not noticed a difference in competence levels.	

1.4	**Appropriate levels of Educational Supervision** Acute internal medicine The foundation trainees confirmed they had met their ESs. Respiratory medicine The foundation trainees said they had all met their ESs and they had been very supportive.	
1.5	**Access to Technology enhanced and simulation-based learning** Acute internal medicine The AIM trainees said that some simulation training had been provided to Trust grade doctors in the past and they attended handover teaching but they did not get formal training in the form of lectures or simulation training. The IMT and GP Vocational Training Scheme (GP VTS) trainees said that the IMT trainees tended to be favoured for teaching such as ultrasound and simulation because it was not part of the GP VTS requirements.	

Domain 2 – Educational governance and leadership

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.

HEE Standard	HEE Quality Domain 2 – Educational Governance and Leadership	Requirement Reference Number
2.1	**Impact of service design on users** General The Director of Medical Education (DME) told the review team that the Postgraduate Medical Education (PGME) team had done a lot of work to ensure the Trust leadership, including the Trust Executive Committee, were aware of the General Medical Council (GMC) National Training Survey (NTS) results for 2021. The DME highlighted that it could be difficult to interpret some of the results as several departments fed into the acute take. The DME said that the Trust had better evidence regarding the quality of recent inductions, with a new induction evaluation system from which more robust feedback had already been shared with Health Education England (HEE). The Workforce Hub Manager said that the workforce hub had been in place for almost a year and recognised that teething issues were still being worked through. The Workforce Hub Manager told the review team that the workforce hub team was working hard to communicate with trainees and meet new incoming trainees, as well as working closely with	

	consultants. The review team heard that the workforce hub was responsible for rejecting and accepting annual leave so there was discussion with trainees around this. The review team heard that meetings between the workforce hub and departments were taking place to resolve any issues, and departments were meeting with trainees to gain feedback to bring to these. The Trust representatives said that rota and workforce issues were still a challenge and the induction and support provided to Trust grade doctors was a key focus. The DME said there was process in place to ensure non-training grade doctors received the usual Trust induction and monthly training sessions. The DME said that Trust grade doctors who were not familiar with the NHS were signposted to the 'induction to the NHS' module on the eLearning for Healthcare website. The Workforce Hub Manager said that the Trust had implemented a standard operating procedure stating that all new starter doctors who were not in training should receive a four-week shadowing period and be clinically signed off by consultants before starting to work independently. The DME said that trainees seemed to not receive feedback from IR1 incident reports and the PGME team was meeting with the IR1 team and had new ideas about how to make responses more transparent. The DME added that a new Director of Quality and Safety had been appointed. The DME confirmed that a Specialty and Associate Specialist Tutor had been appointed. <u>Acute internal medicine</u> The DME said that the GMC NTS results for AIM were better than in 2019 but the Trust recognised they still required improvement. The DME said that there were positive suggestions from the GP VTS results that the department met the needs of GP VTS trainees. The DME told the review team that a business case was currently being prepared for phase two of the measures to improve staffing in AIM which was going to focus on weekend staffing. The DME reminded the review team that phase one had seen a £1.7million investment in the AIM roster to increase staffing. The DME reported that a standard operating procedure for a hospital at night service was being drafted and the DME was confident this would be completed and implemented. The Deputy Chief Medical Officer told the review team that the 'Internal Professional Standards' (IPS) document had been developed in 2019 and approved internally and externally. The Deputy Chief Medical Officer said that the Trust was committed to the document and was putting in place systems to make sure it was adhered to. The review team heard that the document was being implemented with clinical directors and education leads and there were challenges around this, particularly relating to specialty response times to AIM. The review team heard that it was difficult to track these response times because there was no IT system which recorded when a patient was referred to a specialty and when that patient was seen. The review team heard that an audit of this was ongoing. The Deputy Chief Executive explained to the review team that the IPS needed to be read in conjunction with good medical practice and Trust values documents, and a code of conduct document might be developed in the future. The Clinical Lead for AIM said that during the last	

	few months when the IPS has been implemented, the Clinical Lead had worked with a psychologist to listen to emergency department (ED) and AIM staff feedback to solve any issues. The Clinical Lead for AIM said they had not heard of any issues recently. The foundation and GP VTS trainees told the review team that their placements were stressful and the many different IT systems made the job demanding, frustrating and sometimes overwhelming. However, the foundation trainees and GP VTS trainees said that the consultants and senior trainees were very supportive, there was always someone around to help and the placement had been a good learning experience. The foundation trainees said that at Queen's Hospital there was a lot to learn and they saw a variety of cases. The foundation trainees told the review team they did get breaks and generally managed to leave on time, although some trainees had exception reported as they had worked late. The foundation trainees said that staffing numbers were generally good, although on some days they were short staffed. The foundation trainees explained that at King George Hospital, there were two consultants on site who trainees could contact throughout the day. The foundation trainees said that the AIM service at King George Hospital was well-staffed and most days the team had to send staff to other wards. The foundation trainees said that on calls were a bit different as staffing was lower and getting in contact with a senior colleague could be more difficult. The foundation trainees said that weekends tended to be well staffed and they had many opportunities to clerk patients. The foundation trainees told the review team that at Queen's Hospital staffing levels varied between clinical areas but confirmed that weekend staffing was half what it was during the week, although there were still two consultants on the ward. The foundation trainees explained that although there were multiple rota gaps at Queen's Hospital, these were generally filled by locums (a mix of longer-term and shorter-term) and bank staff which meant shifts were fully staffed. The IMT trainees said they found the Trust to be very busy and stressful but were enjoying that as it was a challenge. The IMT trainees said they felt that Queen's Hospital provided a better experience than King George Hospital because the rota was more varied which meant better training experiences. The IMT trainees said that at King George Hospital, the IMT trainees only worked on call or on the Medical Receiving Unit (MRU) whereas at Queen's Hospital, they performed more assessments and other tasks. The IMT trainees said that they were not sure whether the ultrasound teaching available at Queen's Hospital was also available at King George Hospital. The IMT trainees explained that some of the consultants were trying to arrange for trainees at King George Hospital to spend time at Queen's Hospital so they could gain more varied teaching. The IMT3 trainees said they had really enjoyed their first few months as IMT3 doctors as they were treated like higher trainees but were still able to ask questions and seek support when they needed it. The IMT3 trainees told the review team that they were supposed to be paired with a more senior trainee as a buddy for their first month as an IMT3 doctor but not all were (some were paired with each other instead) due to staffing levels. The DME informed that relations between the ED and AIM was an ongoing issue but the Chief Executive was sighted on the challenges,	ARM2.1a

	and problems had been escalated to the division leads. The DME said the Trust was aware that co-locating the teams could improve the working relationship but said that space to allow for this was an issue at Queen's Hospital. The IMT and higher trainees told the review team that relationships between the ED and AIM were antagonistic. The IMT and higher trainees said the ED was under pressure. The IMT and higher trainees informed the review team that the quality of referrals from the ED was poor and it was difficult to know what investigations had and had not been done for patients prior to admission. For example, the review team heard that sometimes trainees were told bloods had been done when they had not. The IMT and higher trainees said that patients who should be referred to other teams often ended up being referred to AIM. The review team heard that trainees did sometimes tell the AIM consultants about these cases but consultants did not always want to get involved. The IMT and higher trainees said that often the AIM team admitted patients who should not have been referred to them and then arranged for other specialties to come and see patients in AIM. The IMT and higher trainees said that a lot of joint care happened in this way and they felt bad for patients but said trying to get them admitted in the correct way was too difficult. The IMT and higher trainees said they pushed quite hard to get surgical reviews for patients in the ED as they found it more difficult to get surgical teams to see patients when they had been admitted by AIM. The IMT and higher trainees explained to the review team that inappropriate referrals from the ED happened due to a lack of competence and junior doctors not knowing which team to refer to. The IMT and higher trainees said junior doctors in ED worked autonomously, referred without speaking to a senior and did not get feedback in the department. The IMT and higher trainees said they gave these junior doctors feedback even though they were not in their team. The review team heard that the ED also referred patients who did not need to be admitted and the IMT and higher trainees thought this would not happen if the junior doctors in the ED had the opportunity to speak to their seniors. The IMT and higher trainees told the review team that the issues with inappropriate referrals were well known by consultants and trainees had escalated this in the past. The ESs and CSs told the review team that during the surges in Covid-19 cases, the ED and AIM worked well together and had relationship meetings in which behaviours were discussed. The supervisors said that the departments had had a joint space in the ED prior to the Covid-19 pandemic which had allowed for better communication but Covid-19 had made this difficult to maintain. The supervisors said that there was a resuscitation huddle which had representation from the ED, anaesthetics, and AIM, and facilitated working together. The supervisors were aware that sometimes inappropriate referrals were made to AIM by the ED and stated that they wanted trainees to tell referring doctors in ED that they needed to discuss cases with the AIM consultant before accepting the referral. The supervisors said that situations were often resolved when the consultants from AIM spoke to the ED consultants and the IPS document had been created in part to remove the junior doctors from these situations. The ESs and CSs said that the ongoing issue of pressures on AIM due to the volume of cases coming into ED were well known and had been escalated to the Chief Medical Officer and Chief Executive. The supervisors highlighted that the Chief Executive had attended a departmental meeting recently to understand the problems	

	further and offer support. The ES and CSs said that solving these issues was a significant piece of work and the Trust was seeking solutions. The supervisors said that to ensure trainees were not being overwhelmed by these pressures and workload, the consultants checked in with trainees at handovers and shared the workload among themselves to make sure the service was consultant-led. The IMT and higher trainees explained that the quality of locum and Trust grade doctors was often poor and that this meant when the department was busy, the trainees sometimes had concerns about the quality of care provided. The IMT and higher trainees said that the doctors in training had to carefully choose which patients to allocate to locum or Trust grade doctors due to concerns that some of them were not competent to see sick patients. The IMT and higher trainees highlighted that doctors in training were a minority in the department so although the department was well staffed, the quality of Trust grade and locum doctors impacted negatively on capacity. The review team heard that clerking by Trust grade and locum doctors was often inadequate and the doctors in training frequently ended up doing all of the clerking at night to ensure quality. The IMT and higher trainees said that the Trust grade doctors did have an initial shadowing period when they started in post but said that this was not an effective mechanism for identifying doctors who were not competent. The IMT and higher trainees told the review team that consultants did not ask their opinions before signing off Trust grade doctors to work on the on call rota. The foundation trainees highlighted they had been shadowed by these doctors which they felt was not appropriate. The AIM trainees said that providing additional teaching to the Trust grade doctors would be very helpful. The AIM trainees said they were aware of complaint emails which had been sent regarding the quality of Trust grade and locum doctors and thought this was a Trust-wide problem. The ESs and CSs told the review team the department had a good track record of supporting non-training grade doctors. The supervisors said that doctors who had not worked in the NHS before arrived with varying levels of training with some being at an IMT level and others being higher. The supervisors said these doctors received a good induction including a period of shadowing and had their own teaching programme which the department had developed. The supervisors said that non-training grade doctors were not treated any differently to trainees in the department with access to eportfolio and the same supervision levels. The ESs and CSs added that these doctors received help with their CVs and personal development plans. The ESs and CSs told the review team that monitoring of clinical competence of non-training grade doctors who had not worked in the NHS before in the department started with the recruitment process. CVs were reviewed to ascertain which doctors were and were not appointable, then interviews took place and when the doctors started, they were closely supervised for three months. At this point, a decision was made about what level post they would work in. The supervisors highlighted that the 10 doctors who were appointed last year were now all in training positions. The supervisors said that the department was known for supporting doctors through the Certificate of Eligibility for Specialist Registration process which made it an attractive department to work in.	ARM2.1b ARM2.1c

	The IMT trainees said that leave requests had been accepted quickly even with less than six weeks' notice and there seemed to be a proactive approach to finding cover for leave. <u>Respiratory medicine</u> The DME explained that the GMC NTS results for respiratory medicine had declined since 2019 and the PGME team had met with the department and trainees to discuss this. The DME told the review team that the department had seen reorganisation and expansion due to Covid-19 and thus there had been a lot of work realigning the service across the two hospital sites which had been difficult. The DME said that two thirds of current respiratory care in the Trust was Covid-19 care. The DME said there were plans to ensure trainees worked on both sites so that they would be able to experience a wider range of cases. The review panel heard that the department preferred to keep foundation trainees on their assigned wards to ensure consistent clinical supervision but it was being investigated how more senior trainees could be moved around. The DME said that the department had a lack of IMT trainees and staffing requirements in the department made it hard to move trainees and ensure they got to do clinics and procedures, but this was a work in progress. The Trust representatives highlighted that treating Covid-19 patients included a lot of general medical experience which trainees could learn a lot from. The ESs and CSs told the review team that Covid-19 had been extremely challenging for the department and there had been many changes including opening an additional ward, shutting down clinics and outpatient appointments and moving from 420 procedures a year to 120. The review team heard that the department had had to focus much more heavily on service provision than on training. The ESs and CSs said the department had seen high levels of morbidity and mortality which had impacted the trainees and the consultants. The supervisors told the review team that there had also been a lot of sickness among trainers with half of the consultant body off sick with Covid-19 at one point and that this had a significant impact on both training and service provision. The supervisors informed the review team that the service was consultant-delivered with consultant ward rounds on both hospital sites every day. They noted that this was difficult to maintain but hoped that it helped the trainees. The ESs and CSs said that while clinics were now open and procedures taking place, the department was still very busy with Covid-19 when the rest of the Trust felt like it was emerging from it. The supervisors said that when a third respiratory ward was opened, the consultant workforce would have benefitted from expansion to allow for better supervision. The review team heard that the foundation year one (FY1) trainees in respiratory medicine worked on the respiratory wards and on the medical take, and the foundation year two (FY2) trainees did additional shifts such as nights. The foundation trainees said they thought the FY1 weekday shifts were not as good a learning opportunity as the FY2 weekday shifts. The foundation trainees said the FY1 trainees did ward rounds in the morning and then joined the take from 13:00 to 20:00 which felt a little disjointed and meant they saw fewer patients and less medicine. The review team heard that FY1 trainees were supposed to be on the medical take all day at weekends clerking patients, with the consultant for advice. The foundation trainees said that sometimes FY1 trainees had to be on the post take ward round at the weekend because there were not enough staff. The foundation trainees told the review team that the ED staff were	ARM2.1d

	generally very nice, felt they could ask them for help and had not had any bad experiences with the department. The foundation trainees told the review team that take shifts were normally well staffed but ward staffing sometimes fell below the specified minimum of four doctors per ward. The foundation trainees said that workload was busy but not overwhelming and there were plenty of learning opportunities such as being able to attend clinics. The foundation trainees informed the review team that when the wards were understaffed, workload could be heavy and they were aware that a few foundation doctors had had to stay late on occasions but agreed that they were generally able to leave on time. The foundation trainees said that they knew how to exception report as they had received a tutorial and told the review team that some foundation trainees had done so. The foundation trainees said there were clinical fellows in the department who were regular faces on the wards. The foundation trainees said there were a lot of locum doctors in the department because the Trust was trying to fill staffing gaps. The foundation trainees told the review team that they felt they had to heavily support locum doctors, especially those who had not worked in the NHS before. The review team heard that the foundation trainees found this uncomfortable and suggested that locum doctors required more training from the Trust. The foundation trainees said that the locum doctors did not know how to use the computers and said it was very difficult to manage and support the locum doctors, especially as some of them responded rudely to trainees. The IMT and higher trainees said that the consultants on the non-Covid-19 ward worked hard but the locum doctors did not. The review team heard that there were a lot of rota gaps on the non-Covid-19 ward and this meant there were different Trust grade doctors on the ward daily, including doctors who had not worked in the NHS before. The IMT and higher trainees told the review team that each ward should have four foundation or IMT doctors but this did not always happen, and more gaps had occurred since the rotas had been coordinated by the workforce hub (removing local oversight of rotas). The IMT and higher trainees said they were concerned for foundation trainees when they were left on the wards with only new Trust grade doctors who had not received a full induction to support them. The IMT and higher trainees felt this made the ward unsafe. The higher trainees said they thought it was unhelpful that the IMT trainees were placed on the Covid-19 ward and the Trust grade doctors on the non-Covid-19 ward. The higher trainees said this made the consultants frustrated and provided no continuity of care as the Trust grade doctors changed every day. The higher trainees said it seemed that an easy solution would be to move IMT trainees across to the non-Covid-19 ward. The IMT and higher trainees said that locum doctors were variable in competency and some had not been in the NHS for long. Some of the IMT trainees highlighted they had not had any problems with Trust grade or locum doctors in the department but said the department seemed to be heavily reliant on them. The IMT and higher trainees said they felt the Covid-19 ward at Queen's Hospital required a review of staffing as sometimes the foundation trainees were left to work alone with locums. The ESs and CSs said that a lot of the doctors coming from overseas who joined the department had not worked for a while, as well as not having worked in the NHS before. The supervisors said that these	

	doctors worked under direct supervision and had to gain competencies but tended to do well. The supervisors said supervising these doctors took a lot of time and effort as often they had to be taught how to write in patient notes and helped with communication problems, as well as taught how to do the full complement of procedures. The supervisors said that if the doctors were staying at the Trust for six months or more, they could have an eportfolio account but if not, the department had created its own proforma system which was filled in and then emailed to the doctor as an audit trail. The supervisors told the review team that it depended which programme the overseas doctors were on as to how much training support they received from the PGME team. The ESs and CSs said that the main barrier to moving trainees around between the Covid-19 and non-Covid-19 wards was the rota as most days the department had the bare minimum staffing. The supervisors said that there were more non-training doctors starting in the department but some were still to start and some had no NHS experience and would require a longer period of induction and supervision. The review team heard that during the height of the pandemic, the department controlled its rotas and could move staff between wards according to need but the rotas were now managed by the workforce hub which reduced the control the department had. The supervisors said the department had weekly meetings with the workforce hub in which they worked together to plan cover for the next two or three weeks. The trainees explained that the workforce hub had continually rejected annual leave for trainees (even when applying with much more than the required six weeks' notice) because the workforce hub thought that this would cause staffing levels to fall below minimum levels. The IMT and higher trainees explained that there seemed to be a disconnect between what the workforce hub thought was the case for staffing and actual staffing numbers. The review team heard that clinical fellows were often not included on the rota so this meant staffing numbers were miscalculated. The foundation trainees said they felt the workforce hub should be able to arrange for locums when given so much notice. The review team was informed that rotas had been managed by higher trainees in the department until August when this responsibility had moved to the workforce hub. The IMT and higher trainees said that they had managed to get leave approved although they said that it was initially rejected and had to be sorted out by the coordinator on the ward. The said these situations were resolved quite quickly once they were escalated but it was difficult at first and trainees had held meetings with the workforce hub and written lengthy emails to try to resolve the issues. The trainees said that not having a local rota coordinator also meant that personal circumstances were not taken into account on the rota (for example, pregnant doctors should not be placed on the Covid-19 wards).	ARM2.1e
2.2	**Appropriate systems for raising concerns about education and training** <u>Acute internal medicine</u> The DME said that local faculty group (LFG) meetings were being structured by the College Tutor so that trainees were asked specific questions relating to HEE open actions. The ESs and CSs said that LFG meetings were consultant led and consultants tried to make sure trainees felt heard and empowered in these meetings.	

	The review team heard that there were LFG meetings every two months in the department in which trainees were supposed to be able to raise concerns but that this felt more like a 'tick box' exercise. The IMT trainees said that the dates of these had not been well communicated which meant the last meeting had not had good trainee representation. The IMT trainees said that if they had concerns in between LFG meetings, they would raise these with their clinical supervisors and felt comfortable to do this. The foundation trainees said they had met the Guardian of Safe Working Hours (GoSWH) virtually at their foundation teaching. The foundation trainees explained they had been invited to a virtual meeting with their training programme directors and the PGME team which had been an open forum for them to raise concerns. The foundation trainees commended the PGME team. The ESs and CSs told the review team the PGME team was very supportive and had helped the department solve many of the challenges it had faced. <u>Respiratory medicine</u> The foundation trainees said the PGME team had made it clear they were always available to provide support and that they would approach this team if they had any significant concerns or wanted to feedback on their training. The foundation trainees said that LFG meetings took place each month where for the first 10 minutes, no consultants were present so trainees could raise concerns more freely. The foundation trainees explained that when the consultants joined the call, a higher trainee then anonymously fed back all of the issues discussed on behalf of all trainees. The foundation trainees said they felt that the consultants attempted to address trainee concerns at these meetings and they did try to help with issues such as staffing levels and IT problems, but the meetings could sometimes feel dismissive. The ESs and CSs said that the PGME team was always there to support trainees and the consultants signposted that. The supervisors also said that LFG meetings provided trainees with the opportunity to feedback and trainees were encouraged to speak to their ESs about any concerns. The foundation trainees said they were aware of who the GoSWH was and that they attended their monthly teaching sessions to speak to the trainees. The review team heard that the FY1 trainees knew of the programme director available to support them but the FY2 trainees did not. The IMT and higher trainees said they had been asked to compile a document of their feedback for this HEE review and said that they could send this through to the review team if they had not yet seen it. The review team received this shortly afterwards.	ARM2.2

Domain 3 – Supporting and empowering learners		
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.		
HEE Standard	**HEE Quality Domain 3 – Supporting and empowering learners**	**Requirement Reference Number**
3.1	**Learners being asked to work above their level of competence, confidence and experience** Acute internal medicine The foundation trainees said they did not think they had been asked to work above their competence level. However, the foundation trainees said that some of the locum doctors did not seem to realise that FY1 doctors needed a little more support than more senior trainees.	
3.1	**Regular constructive and meaningful feedback** Acute internal medicine The foundation trainees said that they did not receive formal feedback from consultants. Respiratory medicine The foundation trainees said they did not regularly get feedback from consultants but did from higher trainees.	
3.1	**Access to resources to support learners' health and wellbeing and to educational and pastoral support** Acute internal medicine The review team heard from the AIM trainees that the PGME team were very good and had recently worked with the department to ensure a trainee experiencing difficulty had received the required support. The ESs and CSs said the PGME team had an open-door policy for trainees and supervisors and they were very supportive. The supervisors told the review team that the PGME team had recently helped the department to improve the experience of one trainee in a very prompt and effective way. Respiratory medicine The ESs and CSs said that after the first and second waves of Covid-19, the department had the support of a psychologist who was available to meet with trainees. The supervisors said the department had recognised the importance of mental health and wellbeing in trainee feedback during the first wave of Covid-19 and had implemented Schwartz rounds, discussed wellbeing in induction and built it into meetings.	

3.2	**Time for learners to complete their assessments as required by the curriculum or professional standards** Acute internal medicine The review team heard that some foundation trainees had not done any of their supervised learning events (SLEs) yet but others said that they had not had any trouble completing these and had been assisted by more senior trainees. The ESs and CSs told the review team that FY1 trainees had protected time in the afternoons when they clerked patients which a consultant then reviewed with them and this helped to get assessments done. The ESs and CSs explained that they regularly asked trainees who needed to get assessments signed off and then helped trainees with these. Respiratory medicine The foundation trainees said they generally did their SLEs with higher trainees rather than consultants due to consultant time restraints. The foundation trainees said the higher trainees were helpful with this.	
3.3	**Shadowing for medical students transitioning to foundation training** Respiratory medicine The foundation trainees said the FY1 trainees had shadowed the outgoing FY1 trainees for 10 days before starting and had learnt a lot from this.	
3.3	**Access to study leave** Acute internal medicine The IMT trainees said they had not had any teaching yet but when they had tried to book time off for future teaching, this had been rejected which they thought was due to a glitch in the system. The IMT trainees said that consultants were very supportive of them attending teaching. Respiratory medicine The FY1 trainees said that the PGME team had informed them of the dates of their half day teaching sessions in advance so that they could book them off. The FY2 trainees reported they had not been informed in advance of their teaching and thought that it was not very regular. The foundation trainees reported that there was some confusion about how to use the system to book teaching days. The higher trainees said they had half days rostered for study leave.	
3.4	**Induction (organisational and placement)** Acute internal medicine The foundation trainees told the review team that their induction had been useful, all the basics had been covered, and they had everything they needed by the time they started. Respiratory medicine The foundation trainees informed the review team that their local induction had been higher trainee led with consultant input and provided general rather than specific information. The IMT trainees said their induction had also been given by higher trainees. The higher trainees said they had received a good local induction and their timetables had been fairly clear. The trainees at King George Hospital explained that they had received	

	their rotas and site information late as they had originally been told they would be placed at Queen's Hospital but this had been changed two weeks prior to their start date. The trainees at King George Hospital explained that had they known this earlier, it would have impacted on accommodation and travel choices.	

Domain 4 – Supporting and empowering educators

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 appropriately supported to undertake their roles.

HEE Standard	HEE Quality Domain 4 – Supporting and empowering educators	Requirement Reference Number
4.4	**Appropriate allocated time in educators job plans to meet educational responsibilities** Acute internal medicine The ESs confirmed they had time in their job plans for educational supervision. Respiratory medicine The ESs confirmed they had time in their job plans for educational supervision but said the increased clinical supervision which had come with opening an additional ward (without an increase in consultant body) was difficult to manage.	

Domain 5 – Delivering curricula and assessments

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.

HEE Standard	HEE Quality Domain 5 – Developing and implementing curricula and assessments	Requirement Reference Number
5.1	**Placements must enable learners to meet their required learning outcomes** Acute internal medicine The foundation trainees confirmed they were released from the rota in order to attend their core teaching. The foundation trainees said that at Queen's Hospital, there was morning teaching three or four times a week which involved case presentations. The review team heard that all trainees were able to attend and it was useful. The IMT and GP VTS trainees at Queen's Hospital said there was an abundance of clinic time and they were welcomed to join clinics with consultants, including specialty clinics. The trainees were not sure	

	whether clinics were available for trainees to attend at King George Hospital and said that trainees seemed to work on MRU every day instead. The ESs and CSs said AIM was the only department which delivered teaching throughout Covid-19 and that the department recognised that good education and a good working environment went hand in hand. The review team heard that the consultants were happy to teach in and out of hours and involved the trainees as much as possible in the department. The supervisors told the review team they provided teaching programmes specifically for preparing for the Royal College exams. The supervisors said they also provided weekly teaching and tutorials for IMT trainees. The ESs and CSs told the review team that ultrasound workshops had been popular with trainees and helped them to learn how to perform a variety of procedures. The supervisors added that trainees had many opportunities to be involved in publications to enhance their portfolios. The ESs and CSs said there was a morning huddle everyday which was consultant led but which empowered trainees to speak, and that even foundation trainees were asked to see patients and then discuss the cases with a consultant. The ESs and CSs informed the review team that higher trainees were supported in many ways and were helped to prepare for leadership roles. For example, the supervisors said higher trainees were empowered to lead handovers (with consultant presence). The supervisors said that when higher trainees were on call, they always knew which consultant was on call and that they could come to see the consultants in their offices if they had any queries. <u>Respiratory medicine</u> The review team heard that some foundation trainees were in placements on the Covid-19 ward and that although the possibility to work on the non-Covid-19 ward to gain varied respiratory medicine experience had been discussed with consultants, the decision had been made that this would not be possible. The foundation trainees said they thought from a learning point of view, the trainees on the Covid-19 wards learnt less than those on the other ward but felt this was less of an issue for foundation trainees than IMT trainees. The IMT and higher trainees agreed that the Covid-19 wards provided them with less experience of respiratory medicine and that this impacted trainees more at IMT level than foundation level. They explained that some IMT trainees working on the Covid-19 wards and were not due to rotate onto the non-Covid-19 ward during their placement, despite requesting to. The IMT trainees explained that there were locums and clinical fellows on the non-Covid-19 ward and they said they felt their training should take precedence, especially where it had already been greatly disrupted by Covid-19. The IMT and higher trainees explained that on the non-Covid-19 ward, the work was varied with chest drains, cancers and general medicine whereas on the Covid-19 ward, the presentations and treatments were very repetitive. The IMT and higher trainees explained that the higher trainees were able to move between the wards but the IMT and foundation trainees could not. The IMT trainees said that on the Covid-19 wards, they frequently finished their tasks by midday and did not have much to do in the afternoon. Some of the IMT trainees said they sometimes left the Covid-19 ward in the afternoon to go to the MRU	ARM5.1

	to read through patient notes. The IMT trainees said the consultants on the Covid-19 wards did try to teach but the trainees still felt they lacked learning opportunities and some said they felt they had lost general medical knowledge. Some of the IMT trainees said that the consultants on the non-Covid-19 ward had been trying to help trainees to get moved off the Covid-19 ward but that this had been blocked by HR and other consultants in the department. The ESs and CSs said that trainees did not want to work in respiratory medicine due to the pandemic and felt Covid-19 wards were not providing adequate training, which was difficult to mitigate. The ESs and CSs said they were aware of the disruption Covid-19 had caused for trainees and they were trying to make training opportunities equal across both hospital sites. The supervisors said that they had tried to provide trainees with non-Covid-19 experience wherever possible including weekly virtual teaching, audits and publications. The ESs and CSs said that there was only one respiratory ward at King George Hospital which was a Covid-19 ward. The review team heard there had been a proposal to change the ward to become dual purpose but this had not gone ahead due to financial restrictions. The review team heard that this was easier at Queen's Hospital where the Covid-19 ward and non-Covid-19 ward were close together and trainees could more easily be informally moved around. The supervisors explained to the review team that the higher trainees had flexibility to move between wards and they spent most of their time on the non-Covid-19 ward. The ESs and CSs said that it was best for foundation trainees to stay on their allocated ward so that no supervision was missed but that the consultants recognised the need to move IMT trainees around, although had been unable to come up with a satisfactory solution as of yet. The ESs and CSs explained that IMT trainees needed more supervision than higher trainees but the department wanted them to gain more experience. The supervisors said some IMT trainees had had challenging attitudes to their experience in the department, requesting to be moved immediately after starting their placements or commenting that they would only spend three of their six-month placements on a Covid-19 ward. The supervisors said they understood that there were competencies trainees had to get signed off, but that the nature of IMT training meant that trainees inevitably missed some specialties and trainees could never fully cover all aspects of medicine. The supervisors noted that trainees also gained a lot of general medical experience on the Covid-19 wards and that they were trying to increase trainee attendance at clinics and procedures. The higher trainees said Covid-19 had impacted on their training greatly but that training opportunities had improved more recently when clinics and bronchoscopy had restarted. The higher trainees said that their timetable was good with a variety of experiences, and clinics had been useful. The IMT trainees said they were pleased they had access to clinics which would enrich their portfolios and that they had no difficulty in getting to clinics, especially if based on the Covid-19 wards as there was not much to do. The IMT and higher trainees said the consultants on the non-Covid-19 ward actively tried to teach trainees and went above and beyond to do this. The foundation trainees told the review team that FY1 trainees received a half day of teaching every three or four weeks. The foundation trainees said that FY2 teaching was also a half day approximately once a month but there were concerns about whether this would be enough to fulfil the	

	required 30 hours of core training. The review team heard that additional teaching was provided weekly by foundation year 3 (FY3) trainees. The review team heard that there was also weekly respiratory departmental teaching on different topics which was currently higher trainee led but would soon include consultant teaching. The foundation trainees said they found this weekly teaching useful and had the opportunity to join in. The foundation trainees said they felt they had a clear plan for what they needed to do, found the consultants to be hands-on and had opportunities to be involved in clinics and research. The higher trainees explained that previously, weekly departmental teaching had been consultant led. However, this had been paused during the second wave of Covid-19 and when the trainees had taken the initiative to restart the teaching, the consultants had not wanted to participate, although bedside teaching and shadowing in clinics had continued. The higher trainees said the peer led teaching had been working well but would have benefitted from more consultant input. The IMT and higher trainees said that following a departmental meeting in recent weeks, consultant input into teaching was due to restart. Some of the trainees who had been due to work at Queen's Hospital before being moved to King George Hospital said the reason they had applied to work at Queen's Hospital was due to the teaching there and now they had to leave early in order to travel to the teaching on the other hospital site. The ESs and CSs said that there was weekly teaching on Thursdays when consultants and junior doctors were present, as well as a registrar forum on Fridays when trainees were expected to present a challenging case where they had learnt something. The supervisors also said additional teaching was available on topics such as x-rays and asthma which trainees were encouraged to attend. The review team heard that trainee attendance at some of these teaching sessions was patchy. The ESs and CSs said that the department had monthly clinical governance meetings including a section on morbidity and mortality in which complex cases were discussed and learning agreed. The supervisors said trainees were encouraged to present in these sessions.	

Domain 6 – Developing a sustainable workforce

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 of 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.

HEE Standard	HEE Quality Domain 6 – Developing a sustainable workforce	Requirement Reference Number
6.1	**Retention and attrition of learners** <u>Acute internal medicine</u> Some of the foundation trainees said they were having a very positive experience and would recommend their placement, while other foundation	

	trainees said that they would not and sometimes felt they were treated like secretaries. Some of the GP VTS and IMT trainees said that they would recommend their placements despite frustrations with the many different systems because they had learnt a lot while others would not because of the infrastructure and inefficiencies in the Trust. The IMT trainees said that looking after five patients took up the same amount of time as looking after eight or nine patients in other Trusts because of the inefficiencies. The IMT trainees said there were high levels of stress and pressures among all staff in the department and trainees could feel that in the department. The IMT trainees told the review team that another issue was that at the weekends, the department would often lose five out of six junior doctors from the take rota because they were needed to cover on other wards. The IMT trainees said the rotas were very unpredictable with no continuity and on the MRU trainees often saw new staff every day. The review team heard that the AIM trainees would not be happy for their friends or family to be treated at the Trust, especially as patients often waited for 48 hours in the ED before being allocated a medical bed. The trainees thought patient experience could be poor in this regard and noted that a third of patients at King George Hospital were often moved across to Queen's Hospital because King George Hospital did not have the ability to treat them (for example, surgical patients). The trainees suggested that there was a degree of resignation towards these issues. <u>Respiratory medicine</u> The foundation trainees explained that they would not recommend their current placements to colleagues. The foundation trainees said they thought the experience of future foundation trainees in the department would be better, as doctors who were new to the NHS would better understand the NHS and how to use the necessary systems. The trainees said the computer systems also negatively impacted their placement experience and in comparison to systems in other Trusts, this was a significant downside. The foundation trainees explained that every aspect of a patient's care was on a different system (for example, blood results, imaging, drugs) and the paper system meant that information could be missed. The review team heard that some staff did not check through all results properly as the paper records meant having to cross-reference between pages to ensure they saw all relevant details. The foundation trainees explained that the consultants made the decisions but the patient care was fulfilled by more junior doctors who were not always competent. The foundation trainees told the review team that for these reasons, they would not be happy for friends or family to be treated in the department. The review team asked the trainees whether they had reported any of the instances when other doctors had not reviewed all patient information sufficiently and the trainees explained that they ended up checking the documentation themselves for fear of being seen as annoying. The IMT and higher trainees said that their placements had a lot of potential but they would not recommend them as they were. Some of the IMT and higher trainees said they had had a lot of problems in their current jobs and had enjoyed them the least of their placements. The IMT trainees said they would not recommend the placement because of the lack of opportunities to work on the non-Covid-19 ward. Some of the IMT trainees said they appreciated the difficulties caused by Covid-19 but also said they thought this had started to become an excuse and that other departments had put measures in place to ensure trainees received as much variety in learning as possible.	

	When asked whether they would be happy for friends and family to be treated by the department, the IMT and higher trainees expressed concerns relating to patient safety. The review team heard that recently, there had been no post take consultant for 24 hours at King George Hospital, meaning patients were not reviewed for 24 hours. The IMT and higher trainees explained that when there was a registrar-level rota gap at the weekend, either a locum was found or one higher trainee was left to be responsible for both the ward and the medical take. The IMT and higher trainees explained they thought this was an excessive workload and was not the safest way to deal with the situation. The IMT and higher trainees explained that consultants were on site but that they tended to stay in their assigned areas rather than cross covering.	

Report sign off

Quaity Review Report completed by *(name(s) / role(s))*:	Chloe Snowdon Learning Environment Quality Coordinator
Review Lead name and signature:	Louise Schofield
Date signed:	19 November 2021

HEE authorised signature:	Gary Wares
Date signed:	24 November 2021

Date final report submitted to organisation:	25 November 2021

What happens next:

Any requirements generated during this review will be recorded and monitored following the usual HEE Quality Assurance processes.

As part of our intention to development a consistent approach to the management of quality across England, Quality Reports will increasingly be published and, where that is the case, these can be found on HEE's national website. Information from quality reports will usually be shared with other System Partners such as Regulators and Quality Surveillance Groups.