Health Education England

# HEE Quality Interventions Review Report

## St George's University Hospitals NHS Foundation Trust
## General Practice (GP), including GP Emergency Medicine, GP Medicine and GP Surgery
## Learner and Educator Review

**HEE London**

**25 November 2021**

**4 February 2022**

Version 0.1

## Review Overview

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| **Background to the review:** | Health Education England (HEE) planned this learner and educator review based on feedback from the 2021 General Medical Council National Training Survey (GMC NTS). The results of the survey highlighted potential issues across several programme groups within General Practice (GP) training in secondary care posts at the Trust, including GP Emergency Medicine, GP Medicine and GP Surgery, as well as for the overall GP post specialty. These potential issues included experience and curriculum coverage, supervision, governance and supportive environment. |
| **Subject of the review (e.g. programme, specialty, level of training, healthcare learner group)** | GP training in Emergency Medicine, Medicine and Surgery |
| **Who we met with:** | The review panel met with 11 GP trainees at specialty training levels one and two (ST1-2).<br><br>The review panel also met with the following Trust representatives and trainers:<br>• Director of Medical Education<br>• Medical Education Manager<br>• GP Training Programme Directors<br>• Deputy Chief Medical Officer<br>• Educational leads for Acute Internal Medicine, Emergency Medicine, Neurosurgery, Otolaryngology, Paediatrics<br>• Clinical supervisors for Acute Internal Medicine, Emergency Medicine, Geriatric Medicine, Neurosurgery, Otolaryngology |

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| **Evidence utilised:** | The Trust provided the following evidence in advance of the review:<br>• AMU F2, ST1-2 rota<br>• Autumn term GP STS programme<br>• Breakdown of GP clinical supervisors<br>• ED rota<br>• Emergency Medicine Local Faculty Group minutes January 2021<br>• ENT LFG 21-04-2021<br>• ENT GP clinic attendance<br>• ENT GP ST1-2 rota<br>• GP survey responses – Oct 2021<br>• GP trainees in hospital posts at SGH<br>• GP trainees specialty list<br>• Guardian of Safe Working Hours GP review 25 November 2021<br>• LFG GP trainee meeting with PGME (GMC NTS 2021) Sept 2021<br>• Medicine rota GIM<br>• Medicine EDM LFG group meeting 26.05.2021<br>• Medicine Senior Health - LFG reporting form October 2021<br>• Neurosurgery ST1-2 rota<br>• VTS Zoom Register – Summer 2020<br>• Zoom register 20-21 |

## Review Panel

| Role | Name / Job Title / Role |
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| **Quality Review Lead** | Anand Mehta<br>Deputy Postgraduate Dean, HEE South London |
| **Specialty Expert** | Sarah Divall<br>Head of School for GP – South London |
| **HEE Quality Representative(s)** | Louise Brooker<br>Deputy Quality, Patient Safety and Commissioning Manager, HEE London |
| **Supporting roles** | Jane Gregory<br>Lay Representative |
| | Louise Lawson<br>Quality, Patient Safety and Commissioning Administrator, HEE London |
| | Kate Alley<br>Learning Environment Quality Coordinator, HEE London |

## Executive summary

The review panel thanked the Trust for the time taken to prepare for the review.

Overall, the trainees were complimentary about the supervision and support they received from their supervisors, other junior doctors and the wider multidisciplinary teams. Several clinical areas and placements were noted as being particularly useful for GP training, including otolaryngology (ENT), paediatric emergency medicine, the injuries area in emergency medicine and the frailty service placement in senior health. In the majority of clinical areas, trainees were released to attend GP teaching most weeks or every week.

Several areas for improvement were also identified. The review panel heard about consistent short staffing in medicine due to sickness and rota gaps, which meant that trainees were often moved to cover different clinical areas. This was often done on a daily basis and at short notice which led to a loss of continuity of care, missed learning opportunities, and a sense of anonymity within the team.

Trainees were concerned that on the Acute Medical Unit there was an emphasis on transferring patients out of the unit and on discharging patients as soon as possible. Trainees felt this had the potential to compromise patient safety and on occasions described having to assertively challenge discharge plans which they felt were not appropriate.

Across several clinical areas trainees reported working late sometimes or often. Most trainees did not exception report, either because they did not know how to do this or because they felt that the time spent on reporting was not worth it. Trainees who did exception report were told they could not be paid overtime and were offered time off in lieu, though they frequently felt unable to take this due to heavy workloads.

The neurosurgery rotation was interesting for trainees, but they questioned the value of this rotation for their future careers in GP.

HEE has set a number of actions in relation to these issues which are outlined above. Initial responses to these are due by 1 March 2022.

## 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**<br>**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** | | |
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| Requirement Reference number | Review Findings | Required Action, timeline, evidence |
| | None | |
| Requirement Reference number | Progress on immediate actions | Required Action, timeline, evidence |
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| **Mandatory Requirements**<br>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. | | |
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| **Requirement Reference number** | **Review Findings** | **Required Action, timeline, evidence** |
| GP1.1a | Trainees reported concerns around the emphasis on patient flow in the acute medical unit and the potential to compromise patient safety. | The Trust is required to provide evidence of clear criteria for discharging patients from the acute medical unit or referring them on to other departments.<br><br>Please provide this by 1 March 2022 in line with the quality management portal reporting cycles. |
| GP1.1b | Some trainees had challenged discharge or referral plans for patients in the acute medical unit but described receiving variable responses from seniors. | The Trust is required to provide evidence of work around psychological safety within the acute medical unit to allow trainees to safely raise concerns, for example psychological safety in teams training.<br><br>Please provide this by 1 March 2022 in line with the quality management portal reporting cycles. |
| GP2.1a | Few trainees were aware of the exception reporting process. | The Trust should provide evidence that the exception reporting process has been communicated to all trainees and that they all have the necessary logins and system access.<br><br>Please provide this by 1 March 2022 in line with the quality management portal reporting cycles. |
| GP2.1c | The GP trainees felt that some of the ENT referral calls were complex beyond their level of competence and required more specialist input to be managed safely. | The Trust is required to provide evidence that all ENT referrals are triaged by a suitably qualified middle-grade specialty doctor.<br><br>Please provide this by 1 March 2022 in line with the quality management portal reporting cycles. |
| GP3.1 | The paediatric pre-operative assessment clinic included taking consent for some complex procedures which the GP trainees did not feel comfortable doing. Consent for procedures should be taken by | The Trust should provide evidence that GP trainees in the paediatric pre-operative assessment clinic are not required to take consent for complex procedures and that these cases are allocated to senior or specialist doctors. This could include clinic timetables and allocation criteria. |

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| | appropriately qualified and experienced doctors. | Please provide this by 1 March 2022 in line with the quality management portal reporting cycles. |
| GP3.3 | In medicine, trainees were frequently moved between clinical areas at short notice, which they found demoralising and compromised their ability to access learning opportunities. | The Trust should review the practice of moving GP trainees to cover rota gaps to ensure that their clinical supervision and access to learning opportunities are taken into account and that they are able to attend teaching.<br><br>Please provide evidence of this by 1 March 2022 in line with the quality management portal reporting cycles. |
| GP3.4 | Trainees advised that there was no formal induction to the neurosurgery post, though there was a shadowing period. | The Trust is required to provide evidence that GP trainees placed in neurosurgery posts undergo an appropriate departmental induction. This should include an induction timetable and confirmation of trainee attendance.<br><br>Please provide this by 1 March 2022 in line with the quality management portal reporting cycles. |
| GP5.1b | Trainees were not always able to attend the weekly GP VTS teaching. | The Trust should ensure that all GP trainees are released to attend VTS teaching. Please provide evidence that rotas are planned to allow this (including on-call shifts) and confirmation that trainees are able to attend the sessions.<br><br>Please provide this by 1 March 2022 in line with the quality management portal reporting cycles. |

## 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 | |
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| **Related Domain(s) & Standard(s)** | **Recommendation** |
| GP1.4 | It would be beneficial for GP trainees in emergency medicine to spend time in the injuries area regularly, for example a day per week. |
| GP2.1b | The trainees suggested that the ENT team would benefit from physician associates to help with workload and continuity of care. |
| GP2.1d | A referral triage role or using phones instead of bleeps could improve the experience of ENT on-calls by enabling the trainees to prioritise calls. |
| GP5.1a | The Trust is advised to consider whether the neurosurgery post is appropriate for GP training. |

## 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) |
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## HEE Quality Standards and Domains for Quality Reviews

| Domain 1 - Learning environment and culture |
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| **1.1.** Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.<br>**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.<br>**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).<br>**1.4.** There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.<br>**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.<br>**1.6.** The learning environment promotes interprofessional learning opportunities. |

| HEE Standard | HEE Quality Domain 1 - Learning Environment & Culture | Requirement Reference Number |
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| **1.1** | **Patient and staff safety**<br><br>**Emergency medicine**<br>The trainees reported feeling generally safe while working in the emergency department (ED), but they felt the need to remain vigilant to protect themselves, particularly in paediatric ED where they found patient expectations and attitudes could be harder to manage. The trainees noted that the Trust served a large patient population with significant levels of deprivation. However, compared to other hospitals they had worked at, the trainees felt the security team in ED were very responsive and they found this reassuring. The supervisors in ED noted that staff and trainees were issued pinpoint alarms which raised alerts with the central security team and within the department. The Trust reimbursed staff and trainees for the cost of taxis home if they left work after midnight, but at a recent Local Faculty Group (LFG) meeting, the supervisors had realised that trainees were not aware of this. The supervisors advised that all trainees had now been informed of this and that a member of the security team had spoken to trainees to encourage them to contact security if they felt unsafe leaving the hospital at night.<br><br>**Medicine**<br>The trainees expressed concern that in acute medicine the emphasis on maintaining patient flow and particularly on discharging patients as soon as possible had the potential to compromise patient safety. The review panel heard of instances where trainees had felt the need to assertively challenge discharge or referral plans, including one where a patient had been discharged but had deteriorated and was later admitted to the intensive care unit. When the trainees challenged plans or raised concerns about this issue, they reported variation in how well this was received by seniors.<br><br>**Surgery**<br>The trainees felt that patient safety in the otolaryngology (ENT) and neurosurgery wards was maintained by them working additional hours, as they did not think there was enough time during their shifts to complete their work in a safe and thorough manner. It was suggested that if they left work on time, they would worry that they had missed key points or left work undone. | Please see actions GP1.1a and GP1.1b |
| **1.4** | **Appropriate levels of Clinical Supervision**<br><br>**Emergency medicine** | |

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| | The clinical supervision in ED was reported by trainees to be good as the majority of patients needed to be discussed with a consultant so there was frequent contact with seniors. It was noted that at night, when there was one consultant and one middle-grade doctor on shift, there were sometimes delays in discussions for less acutely unwell patients, but trainees did not feel this was unsafe.<br><br>Some trainees had spent time in the injuries area of ED and found this valuable. However, because it was not officially a part of the GP rotation there was no-one responsible for supervision there and trainees relied on staff having the will and time to supervise them.<br><br>**Surgery**<br>The Trust management representatives acknowledged that there had been challenges in providing clinical supervision for trainees in the emergency 'SOS' clinic. Trainees had been encouraged to give feedback on this and the Trust was seeking solutions. | Please see recom-mendation GP1.4 |
| **1.4** | **Appropriate levels of Educational Supervision**<br><br>**Emergency medicine**<br>The review panel was informed that as standard educational supervisors in ED (ESs) were responsible for three trainees each, though this varied depending on capacity and other responsibilities. During the COVID-19 pandemic, consultants had taken on additional operational responsibilities within the department as some colleagues were shielding, so those who were not shielding took on more supervision. This meant that some trainees did not meet their ED ESs in person, but that these consultants had more time and capacity for supervision activities. The department had weekly consultant meetings where training was discussed as well as 'closed' local faculty group (LFG) meetings every few months where there were no trainee representatives, so supervisors could discuss any concerns around trainees in a private forum. | |
| **1.6** | **Multi-professional learning**<br><br>The trainees felt that their colleagues respected GP training, though they had observed some negative attitudes towards GPs at the interface between primary and secondary care and sometimes they had questioned this to try and change people's perspectives. | |

| **Domain 2 – Educational governance and leadership** |
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| **2.1.** The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.<br>**2.2.** The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.<br>**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.<br>**2.4.** Education and training opportunities are based on principles of equality and diversity.<br>**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 |
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| **2.1** | **Effective, transparent and clearly understood educational governance systems and processes**<br><br>The Director of Medical Education (DME) advised that there were LFG meetings in each department but no GP-specific LFG. However, it was noted that GP training was discussed within the specialty LFG meetings and the DME said that the departmental teams and Training Programme Directors (TPDs) had been good at working with the Postgraduate Medical Education (PGME) team to ensure GP training was taken into account. The DME also attended the weekly Voluntary Training Scheme (VTS) sessions. Therefore, the Trust management representatives did not believe that a separate GP LFG was needed.<br><br>Several trainees reported working late, particularly in the neurosurgery post, where working an additional three to four hours per shift was described as being a regular occurrence. Only two of the trainees in attendance had submitted an exception report; several others were unsure of how to do this. The trainees reported that they had not been shown how to submit exception reports and did not know whether the reports went to the Royal Free Hospital (as lead employer for GP trainees) or to the Trust. Those who had submitted exception reports advised that they had met with a consultant to discuss their reports and that they had been informed they could not be paid overtime but would be given time off in lieu (TOIL). The trainees did not feel that this was suitable as they worked late due to high workloads in their teams and did not want to take TOIL and leave their colleagues with even more work.<br><br>**Emergency Medicine**<br>The supervisors reported that there was a rota working group which reviewed staffing weekly and planned four to six weeks ahead so that gaps could be covered as far as possible. Additional locums had been brought in on late shifts on Mondays and Tuesdays which were known to be particularly busy in the department. The review panel heard that rotas were also discussed at the LFGs and the GP trainee rota had been altered to protect teaching time for the current cohort in response to feedback that previous trainees could not attend VTS and departmental teaching.<br><br>**Medicine**<br>The trainees reported that the senior doctors and managers in medicine were generally good to work with but felt that they lacked time and capacity to deal with concerns raised by trainees in relation to their training.<br><br>**Surgery**<br>The TPDs were aware of feedback indicating that trainees had been working additional hours to complete tasks and, in some cases, found it difficult to access relevant learning opportunities. It was suggested that core trainees were prioritised for access to clinics which reduced the number available for GP trainees. The supervisors were aware of some exception reports submitted by GP trainees in ENT and said that they had encouraged trainees to take TOIL as they were for short periods of time. | Please see action GP2.1a |
| **2.1** | **Impact of service design**<br><br>The TPDs acknowledged that during the COVID-19 pandemic workloads had been very high and many GP trainees were redeployed, which impacted on clinical supervision. Some trainees who were redeployed had had debriefing sessions with their ESs before moving back to their regular rotations, but the | |

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| | TPDs suggested that if further redeployment was necessary, they would also implement clinical supervisor (CS) debriefs.<br><br>**Emergency medicine**<br>The trainees found shifts in ED hard when it was busy and advised that it had been running at capacity for the majority of the time since August. This made it difficult for the trainees to find spaces to review patients and meant that they sometimes struggled to get nurses or other staff to support with tasks such as phlebotomy or administering medication. The trainees felt that having more of this type of support would help to ensure patients were discharged or referred more quickly but understood that their colleagues were also very busy and had to prioritise more acute cases.<br><br>The supervisors explained that the ED included two 'majors' areas, eight resuscitation bays, and paediatric ED. There was also an injuries area, which was mainly staffed by nurse practitioners and had been developed during the COVID-19 pandemic to separate patients with minor injuries from those with suspected virus symptoms. The review panel heard that most of the GP trainees' time was spent in majors, with time allocated for paediatric ED and resuscitation. The supervisors noted that GP trainees were prioritised for access to paediatric ED as it was considered to be a more important learning opportunity for them than for foundation trainees or clinical fellows. The supervisors had observed more staff and trainees moving to a less than full-time working pattern since the pandemic began and felt that the department was supportive of this, although it had led to some rota gaps. Overall, the supervisors reported that the department was well-staffed and had a good level of senior cover, as well as non-medical roles such as emergency practitioners, physician associates and advanced clinical practitioners.<br><br>**Medicine**<br>The trainees reported that the acute medicine on-call shifts were the most challenging aspect of the medicine rotations, largely due to short-staffing and high sickness levels which meant that trainees often held multiple bleeps as there was only one junior doctor on shift at their training level instead of three. During the day, the trainees described being moved at very short notice between different clinical areas to cover for rota gaps. This reduced continuity of both patient care and trainee supervision, as well as reducing trainees' time in areas relevant for GP training such as senior health. Trainees had escalated this issue to the department management, who they described as apologetic, but unable to make changes in the face of rota gaps and staff sickness. The trainees also noted that there had been a long period where there was no rota coordinator in place, which made it more difficult to find out about rota gaps in advance or to get leave approved. When the rota coordinator was appointed, the trainees said that they would have preferred to receive official communication of this.<br><br>The review panel heard that the department planned to employ three physician associates across medicine, but overall staffing remained a challenge and one doctor from the senior health team had recently been moved onto the COVID-19 rota which was likely to impact further. It was reported that supervisors in medical specialties still tried to ensure their trainees had access to learning opportunities and teaching when they worked together. However, the senior health supervisor agreed that trainees across the department (not only GP trainees) had had to do a lot of cross covering and acute medicine on-calls recently, which reduced the time spent in their planned rotations and impacted on their training experience. | |

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| | The senior health supervisor explained that trainees spent half of the senior health rotation in the frailty service, where workloads were more manageable and flexible, allowing time for study leave and access to other learning opportunities. The review panel heard that the department was considering having GP trainees in community placements spend time in the senior health team so that they could focus on the specialty and not be drawn into the acute medical rota.<br><br>**Surgery**<br><br>The ENT ward was described as being frequently busy, with up to 40 patients at times of peak activity. In addition, trainees reported that there were patients situated across other wards, for example paediatric patients and patients having elective procedures who could only be admitted to wards classified as 'green' for COVID-19 risk (the ENT ward was rated 'amber'). This led to prolonged time taken to review patients, as it took around eight minutes to cross the hospital site. The trainees found that the ENT posts carried a significant burden of administration and simple ward jobs, which they were capable of doing but which could, in theory, have been done by others such as foundation trainees, nurses or physician associates. It was suggested that introducing physician associate roles to the ENT ward would improve continuity of care as well as improving trainee workloads. The supervisors indicated that the administrative work done by the trainees could involve complex discussions and changes of medication, as well as giving the trainees opportunities to liaise with other teams around cases requiring multi-specialty input.<br><br>The supervisors explained that the trainees' ENT on-call shifts ran from 08:00-20:00. Each week there was a 'hot' consultant and middle-grade doctor, with the consultant providing 24 hour on-call cover for the full week. The review panel heard that during daytime on-call shifts on weekdays and weekends the GP trainees were responsible for taking referral calls from ED, and that from 17:00-20:00 they also took referral calls from other hospitals in south London. Overnight these referrals were taken by specialist nurses. From 17:00 there was a middle-grade doctor on-call who could be off-site but had to be able to come into the hospital within 20 minutes when required. The trainees felt well-supported by the nurses and other on-call doctors. However, the trainees were concerned that they did not have the appropriate expertise to take specialist referral calls. It was suggested that either the referrals should go to ENT specialist nurses or doctors, or that the trainees required increased clinical supervision to safely carry out this task. At weekends, the trainees believed they were meant to be paired with a core surgical trainee (CST), but the review panel heard that this rarely happened. Trainees who had worked with a CST on these shifts described this as a very positive experience.<br><br>The trainees reported that there were high numbers of bleeps, mainly from ED and from paediatrics. The volume was increased by repeated bleeps about the same patients which did not necessarily correspond with the urgency of the request or the patient's condition, so trainees could get multiple bleeps about relatively minor issues. Additionally, trainees advised that they had given feedback to the paediatrics department about the number of unnecessary bleeps they received. Trainees were aware of other Trusts utilising bleep triaging or had phones instead of bleeps to better allow junior doctors to prioritise tasks. | Please see recom-mendation GP2.1b<br><br>Please see action GP2.1c<br><br>Please see recom-mendation GP2.1d |

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| | The emergency 'SOS' ENT clinic had been raised as a challenge at previous reviews, but the current trainees did not report this to be the case, although they thought the appointment times should be extended from 20 minutes to 30 to avoid overrunning. | |

## 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 |
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| **3.1** | **Learners being asked to work above their level of competence, confidence and experience**<br><br>**Surgery**<br>The multidisciplinary team in ENT was described as very supportive and friendly, and generally very understanding of the appropriate remits for different groups and grades of trainees. However, both GP and surgery trainees were included in the rota for paediatric pre-operative assessment clinics, which included taking consent for a range of procedures, some of which were complex. The GP trainees felt that this was beyond their level of competence and had given this feedback to their supervisors. The review panel heard that the trainees were not pressured to take consent for complex procedures, but that there was not always a consultant present to escalate to. It was suggested that some of the surgical trainees did not feel prepared for this task either, but the review panel did not meet with any of these trainees to confirm this. | Please see action GP3.1 |
| **3.1** | **Access to resources to support learners' health and wellbeing and to educational and pastoral support**<br><br>**Medicine**<br>The senior health supervisor reported that the Trust had been proactive in offering support to staff and trainee morale including rest areas, vouchers, free food at events and access to psychological support. It was not known how many people had taken up the psychological support service, but it was thought that the consultants in general were good at signposting it to trainees. In acute medicine, the Trust was considering over establishment of staff in order to mitigate against short staffing due to sickness. | |
| **3.3** | **Learners feel they are valued members of the healthcare team**<br><br>**Emergency medicine**<br>Trainees described shared points of stress and frustration between team members in the ED but this did not translate to disrespect or poor treatment as it was common to everyone.<br><br>**Medicine** | |

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| | The trainees found the Acute Medical Unit (AMU) a difficult place to work in terms of culture and communication. The trainees believed that the rota and high workloads were the main causes of this, as there were a large number of staff who rotated through the unit, shifts were very busy and therefore people lacked the time and the motivation to get to know one another. Trainees described a sense of anonymity which they found demoralising and reported being addressed by their roles instead of their names. Some advised that they had had difficulty booking annual leave or time off in lieu (TOIL), despite there being consultant oversight of the rota. | Please see action GP3.3 |
| **3.4** | **Induction (organisational and placement)**<br><br>**Surgery**<br>It was reported that there was no formal induction to the neurosurgery post, only a period of shadowing on starting in post. | Please see action GP3.4 |

## 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 |
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| **4.4** | **Appropriate allocated time in educators job plans to meet educational responsibilities**<br><br>**Emergency medicine**<br>The supervisors had 0.25PA (planned activities) per trainee allocated in their job plans, which were reviewed annually. This allocation included both ES and CS activity.<br><br>**Surgery**<br>The supervisors reported that they had time allocated in their job plans for supervision activity. During their rostered 'hot' week, consultants were on-site from 08:00 to 13:00 to work within their subspecialty, followed by other activities such as clinics in the afternoon which could be off site. However, the supervisors advised that if workload in the department looked particularly high in the afternoon, they could cancel off site activity to stay and support the junior doctors. | |

## 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 |
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| **5.1** | **Placements must enable learners to meet their required learning outcomes**<br><br>**Medicine**<br>The review panel heard that there was an unfilled junior clinical fellow post in paediatric neurosurgery, which had impacted on the paediatric GP training rotation. The TPDs explained that this rotation was meant to include minimal time in paediatric neurosurgery but that it had not been possible to maintain this due to the rota gap. The trainees also gave feedback that paediatric neurosurgery was still part of this rotation.<br><br>The DME noted that workloads across medicine were high and that the rota coordinators were aware of the resulting risk of burnout. The DME advised that the number of consultants on-call for acute medicine had been increased to five and the number of middle-grade doctors on-call overnight had been doubled. It was agreed that this support was important but that the department still needed to consider how to ensure that posts were relevant for GP training, and it was suggested that clinics, ambulatory care and day assessment unit might be more useful than acute medicine on-calls.<br><br>**Surgery**<br>Trainees described positive experiences working in neurosurgery in terms of teamwork and support but did not think the post was very relevant to GP training. The Trust management representatives and supervisors were aware of this and reported that the department was investigating ways to adjust the post to cover more of the GP curriculum and how this would fit into overall Trust workforce plans. The trainees agreed that there were some useful learning opportunities available in neurosurgery such as headache and back pain clinics but that they found it difficult to attend these due to workloads. The neurosurgery team meetings included case discussions and trainees would be asked questions as part of these. The supervisors indicated that the consultants were aware of tailoring these questions to the trainees' level and programme, but trainees felt that these meetings could be intimidating for those who were new to the department.<br><br>The supervisors advised that the department had recruited an additional locally employed doctor to help support the rota and enable trainees to access a 'theatre' week (which also included time in clinic). It was acknowledged that trainees still had difficulty accessing clinics but that further recruitment was underway, and it was hoped that new staff would start in early 2022, leading to more manageable workloads and opportunities for more focus on learning. The supervisors reported that trainees were given clinic timetables at induction so that they would know what learning opportunities were available. They noted that GP trainees were not asked to attend specialist clinics which were not relevant to their training and that it was expected that trainees would be able to attend clinics on an ad hoc basis once staffing levels allowed this.<br><br>The review panel was informed that the supervisors planned to include time working on external referral triaging in the neurosurgery rotation, as the current GP trainee in post had found this beneficial.<br><br>The ENT rotation was described as very useful and relevant by the GP trainees. The supervisors discussed the work which had been done since August 2021 to improve training in the department, as there had initially been vacancies in the team and the general manager was not aware of the needs of trainees. The supervisors planned for the rota to include more | Please see recom-mendation GP5.1a |

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| | supernumerary clinics for trainees from December 2021 onwards and the department was recruiting to two vacant posts to help fill the rota. | |
| **5.1** | **Appropriate balance between providing services and accessing educational and training opportunities**<br><br>**Emergency medicine**<br>The trainees were able to access VTS teaching but reported that a lot of departmental teaching had been cancelled and found that it was difficult to complete their e-portfolios due to high workloads.<br><br>**Medicine**<br>The TPDs believed that there were posts in medicine where GP trainees were not released to attend VTS teaching and expressed concern about the impact of this on their ability to build a support network with trainees based in other departments.<br><br>**Surgery**<br>The supervisors thought that trainees were able to attend VTS teaching, but noted that trainees were asked to arrange shift swaps themselves if their on-calls fell on a teaching day. | Please see action GP5.1b |

| **Domain 6 – Developing a sustainable workforce** |
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| **6.1.** Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.<br>**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.<br>**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.<br>**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 |
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| **6.1** | **Retention and attrition of learners**<br><br>**Medicine**<br>Trainees advised that they would not recommend the GP Medicine posts to their colleagues in training. | |

## Report sign off

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| **Quaity Review Report completed by** *(name(s) / role(s))***:** | Louise Brooker<br>Deputy Quality, Patient Safety and Commissioning Manager |
| **Review Lead name and signature:** | Anand Mehta<br>Deputy Postgraduate Dean, HEE South London |
| **Date signed:** | 13 January 2022 |

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| **HEE authorised signature:** | Geeta Menon<br>Postgraduate Dean, HEE South London |
| **Date signed:** | 3 February 2022 |

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| **Date final report submitted to organisation:** | 4 February 2022 |

## 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**