Health Education England

HEE Quality Interventions Review Report

Lewisham and Greenwich NHS Trust (Trust-wide)
Medicine
Learner and educator review

HEE London
Date of Review/Intervention: 24 February 2022
Date of Final Report: 12 May 2022

Review Overview

Background to the review

A risk-based Learner and Educator review was planned following the release of the 2021 General Medical Council (GMC NTS) results, which identified several areas of concerns across programme groups, including (but not limited to):

- Internal Medicine Training level one - 13 red outlier results against the indicators Overall Satisfaction, Reporting Systems, Workload, Handover, Supportive Environment, Induction, Curriculum Coverage, Educational Governance, Educational Supervision, Feedback, Study Leave, Rota Design and Facilities
- Medicine foundation year two – four red outlier results in Clinical Supervision out of hours, Reporting Systems, Handover and Supportive environment. There were also three pink outlier results in Overall Satisfaction, Clinical Supervision and Teamwork.

There were additional areas of concern within Medicine across the Trust when the data was considered at post-specialty level. Previous HEE interventions include an Educator review on 25 October 2019 and a Learner and Educator review on 13 November 2018.

Subject of the review: Training programmes in Medicine, including all training levels and trainees from both the University Hospital Lewisham (UHL) and Queen Elizabeth Hospital (QEH) sites.

Who we met with

18 trainees in foundation year one (F1), Internal Medicine Training levels one, two and three (IMT1-3), general practice (GP) and higher training programmes in Medicine at UHL and QEH
Clinical and educational supervisors
Medical Director
Assistant Director for Medical Workforce and Medical Education
Director of Medical Education
Medical Education Manager
Head of Medical Education
Guardian of Safe Working Hours
Deputy Guardian of Safe Working Hours
Clinical Directors for Acute Medicine
Educational Leads
Divisional Medical Director – QEH
Divisional Director for Medicine and Community – UHL
Training Programme Directors for foundation, GP, IMT and medical specialties

Evidence utilised

Annual Staff Survey results
Breakdown of learner groups in Medicine
Supervision records
Summary report from Guardian of Safe Working Hours
Local faculty group meeting minutes
Medical Education Committee minutes
Induction feedback
QIA evidence
Simulation session records
Summary of Datix reports involving trainees
Teaching session records

Review Panel

Role	Name, Job Title
Quality Review Lead	Geeta Menon Postgraduate Dean, South London HEE London Anand Mehta Deputy Postgraduate Dean, South London HEE London
Specialty Experts	Andrew Deaner Head of the London Specialty School of Medicine HEE London Jan Welch Director of the South Thames Foundation School HEE London Sarah Divall Head of School for GP, South London HEE London
HEE Quality Representative(s)	Louise Brooker Deputy Quality, Patient Safety and Commissioning Manager HEE London
Supporting roles	Robert Hawker Lay representative
	Louise Lawson Quality, Patient Safety and Commissioning Administrator HEE London

Executive Summary

The review panel thanked the Trust team for their work in preparing for the review. However, the review is considered to be incomplete as no GP trainees, no foundation year two (F2) trainees from either site, and no F1 trainees from the UHL site were in attendance. HEE plans to run short surveys for the groups of trainees who were missing from this review and give further feedback after this.

The review panel identified some areas of positive feedback during the review. The Trust had developed a comprehensive wellbeing programme for junior doctors, particularly the foundation trainees. The Trust was working towards a more multiprofessional way of working. The review panel felt that there was scope to develop this further, and it was acknowledged that some plans around workforce transformation had been paused during the COVID-19 pandemic. The physician associate (PA) training programme was described as being well-run and having positive outcomes in terms of training numbers and retention of qualified PAs.

There were also several areas for improvement identified by the review panel. One immediate mandatory requirement (IMR) was issued at the review, please see M3.5b in the Review Findings section below.

The review panel heard from the Trust management representatives, trainees and supervisors that workloads were high and that this was largely driven by rota gaps and difficulty in recruiting both medical and non-medical staff. In particular, the overnight junior doctor cover at both sites was described by trainees as insufficient. At UHL the trainees reported receiving very high numbers of bleeps overnight, which were not triaged. This could be resolved by senior nurses triaging the bleeps or by having different bleeps held by different team members. IMTs reported sometimes staying until 10:00 or midday following a night shift for the post take ward round.

None of the IMTs at the review said they would recommend their wards to friends and family requiring treatment. Most cited understaffing and level of workload leading to delays as their main causes for concern. Most of the IMTs at the review stated that they would not recommend their posts to colleagues for training.

Review findings

This is the main body of the report and should relate to the quality domains and standards in HEE's Quality Framework, which are set out towards the end of this template. Specifically, mandatory requirements in the sections below should be explicitly linked to the quality standards. It is likely that not all HEE's domains and standards will be relevant to the review findings.

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 clinical 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 Review Findings section. Requirements identified should be succinct and not include the full narrative from the Review Findings.

Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
M1.4	The F1s at QEH were unsure of the formal feedback mechanisms available to them such as local faculty group meetings.	Please provide evidence that information about the forums and other feedback mechanisms open to the foundation trainees have been communicated to them. Please provide this evidence by 1 June 2022.
M1.5a	The IMTs and higher trainees at QEH were concerned that there was insufficient middle-grade cover at night and that this constituted a patient safety risk.	Please provide evidence that there is sufficient out of hours middle-grade junior doctor cover at QEH to ensure patient safety and provide appropriate support and supervision to the foundation and IMT1 and IMT2 trainees. Please provide this evidence by 1 June 2022.
M1.5b	The trainees at both sites reported receiving excessive numbers of bleeps while on-call. These were not triaged or regulated so not all of them were appropriate for the level of trainee they were directed to.	Please provide evidence of work to improve this, for example guidance for nurses around which referrals are directed to which bleep, or a bleep triaging system. Please provide this evidence by 1 June 2022.
M3.5a	The F1s were unaware of the hospital at night arrangements. They did know who their direct supervisors and members of their individual teams were on night shifts, but did not know if there was a hospital-wide hospital at night team.	Please provide evidence of communication to the foundation trainees around hospital at night cover. Please provide this evidence by 1 June 2022.
M3.9	The IMT induction did not include information to prepare	Please provide a revised induction programme for IMT

	trainees starting IMT3 to move into the on-call medical registrar role.	including a section to prepare those starting at IMT3. Please provide this evidence by 1 June 2022.
M5.1	IMT and higher trainees at QEH did not have clinic time included in their rotas and often reported finding it difficult to arrange to leave the wards for clinics.	The Trust should ensure that the IMT, GP and higher trainees at QEH have rostered clinic time as the trainees at UHL do. Please provide copies of trainee rotas for QEH including time for clinics. Please provide this evidence by 1 June 2022.
M5.6	IMTs at both sites advised that teaching was not bleep-free.	The Trust should ensure that trainees' teaching sessions are protected as mandated by the GMC. Please provide evidence in the form of trainee feedback showing that training is bleep-free. Please provide this evidence by 1 June 2022.

Immediate Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
M3.5b	The review team heard that trainees could not always access senior advice as they did not know which consultant was on call for each specialty and neither did the switchboard staff.	The Trust is required to ensure that the consultant on-call rotas or each ward and specialty are available to all junior doctors and to the switchboard staff. This applies to both in and out of hours cover.
Requirement Reference Number	**Progress on Immediate Actions**	**Required Action, Timeline and Evidence**
M3.5b	1. The problem was identified as being an issue with switchboard who were not accessing the correct page on the Trust intranet. The Communications and Engagement Manager has now shared the link with ISS in order for the Switchboard team to check and view the on-call rotas - this should avoid any further escalations. 2. On both sites the	Please provide evidence in form of trainee feedback to confirm that this issue has been resolved.

	rota is emailed to all trainees and to switchboard on a weekly basis. If amendments are made these are also circulated by email 3. We will resurvey our medical trainees in due course to ensure that the problem has been resolved.	

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.

Related HEE Quality Framework Domain(s) and Standard(s)	Recommendation
2.8	The Trust is advised to work with HEE around workforce transformation plans.

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/Professional Group/Department/Team	Good Practice	Related HEE Quality Framework Domain(s) and Standard(s)
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HEE Quality Domains and Standards for Quality Reviews

HEE Standard	HEE Quality Domain 1 Learning Environment and Culture	Requirement Reference Number
1.3	**The organisational culture is one in which all staff are treated fairly, with equity, consistency, dignity and respect.** None of the F1 trainees at the review reported experiencing bullying or undermining behaviour. The IMTs and higher trainees described examples of inappropriate language and undermining comments from certain consultants, including reports of such experiences from other trainees. Trainees advised that they had reported some of these instances to supervisors or via trainee representatives, though not all of the reports had led to action or resolution.	
1.4	**There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.** The IMTs and higher trainees described the Trust as being open to receiving feedback but that when issues were raised they were frequently told that the problem was down to a lack of candidates to recruit to vacant junior doctor roles. The IMT and higher trainees were aware of local faculty group (LFG) meetings and other feedback opportunities which trainees or trainee representatives attended, but the F1s were unsure of which regular forums were available for them to give feedback. The supervisors reported being surprised by the GMC NTS results as trainees had raised issues in the survey which they had not discussed previously in supervision meetings. In particular, they stated that the feedback around acute medicine had largely been positive. The Education Leads advised that they discussed the role of educational supervisors (ESs) at induction and made sure trainees were aware of the feedback mechanisms available to them. The supervisors reported that there were IMT and higher trainee representatives who attended the LFGs and sector meetings, as well as frequent trainee surveys to identify issues throughout the year. The LFG meeting minutes were circulated to trainees and the Education Leads said that they had an ‘open door’ policy around meeting with trainee representatives if they needed to raise concerns between LFG meetings.	Please see M1.4
1.5	**Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.**	

	QEH The review panel heard that when the F1s had worked overtime they had been able to claim time off in lieu (TOIL), either formally through the exception reporting system or through informal agreement with their supervisors. In some cases, trainees had built up TOIL entitlement which they had not been able to take during the relevant placement and planned to request payment for the hours worked instead. The IMT and higher trainees raised concerns about the junior doctor staffing overnight at QEH. They described high workloads, with 35 to 40 admissions in a busy night and 350 to 400 patients on medical wards with only one middle-grade level doctor on-call most of the time (supported by more foundation and IMT1 and 2 trainees and a non-resident on-call consultant). The IMTs informed the review panel that there should be two middle-grade doctors on-call, and that they had raised this with the Trust as a potential patient safety risk, but that due to staffing shortages there were not sufficient doctors to cover the rota fully. The review panel heard that during the week of the review, a consultant was covering a set of these shifts as there were no IMT3 or higher trainees available. F1, IMT and higher trainees all raised that bleeps were not triaged. This had led to F1s being called to see unwell patients and requiring more support, and IMT and higher trainees receiving high numbers of bleeps. The review panel heard that this made it difficult for trainees to prioritise patients and made it hard for them to complete tasks as they were frequently stopped to respond to bleeps. The trainees explained that there was a hospital-wide handover system which was linked to the patient records software. The trainees reported that there was designated time in their shifts for handover. The morning handover was described as relying on the electronic tool, and if there was a face-to-face handover, this was done on an individual basis between the doctors on the night shift and their counterparts who were taking over on the day shift. The F1s were divided in terms of whether the electronic handover was safe and sufficient, with some suggesting that a verbal handover would be better and that patients could be missed in the electronic handover. Evening handover was reported to be more structured and the F1s felt that the twilight shift helped to support this and ensure that the night team were fully informed. When asked whether they would recommend their posts to colleagues, most of the IMT and higher trainees said that they	Please see M1.5a

	would not and the F1s said that this depended on which clinical area they were placed in. Cardiology was described by the F1s as well-supported, with consultants who were willing to teach and strong multi-disciplinary team working. There was one F1 post which worked across multiple specialties, and this was felt to be very educationally valuable. The majority of the trainees said that they would not recommend the hospital to friends and family members requiring medical care due to poor staffing levels and delays to some clinical investigations and administrative processes. **UHL** The IMT and higher trainees reported that night shifts on-call could be intense and that it was common in certain rotations to finish late, sometimes as late as 10:00 or midday. Trainees had submitted exception reports and been paid for the additional hours but they were not aware of exception reports being followed up or of changes being made to avoid the need to work additional hours. The IMTs described receiving high numbers of bleeps which made it difficult to complete tasks or prioritise patients, and short staffing which often meant there were only two IMT1 or IMT2 level doctors on shift to cover the medical wards, acute medical take and geriatric medicine take. They described the middle-grade trainees as willing to help them where possible but were aware that their workloads were also high. The trainees suggested that bleeps should be triaged, for example by a senior nurse or advanced nurse practitioner, which would ensure that trainees received appropriate bleeps for their role and training level and would assist them in prioritising tasks and patients. The trainees advised that they had fed this back to the Trust, most recently through an internal survey. The handover system at UHL was the same as that at QEH. The trainees advised that previously handover had been informal but that the computer system used at QEH had been introduced to UHL in the past few weeks. The review panel heard that there was no formal team handover in the morning but that there was in the evening. Prior to weekends, there was a team handover on Friday afternoons. None of the IMT and higher trainees at UHL said that they would recommend their training posts to colleagues or that they would advise friends and family to be treated there.	Please see M1.5b
1.9	**There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence-led practice activities and research and innovation.**	

	The review panel was informed that the Training Programme Directors had surveyed the IMTs and worked with them to create objectives and action plans following the release of the GMC NTS results. Outcomes included implementation of a teaching programme which was more closely linked to the curriculum, building clinics into trainee timetables at UHL and recording the induction sessions so trainees could refer back to them if needed. The Medical Director noted that the teams at both sites had worked hard on this and that further work was ongoing to improve the physical environments at both sites.	

HEE Standard	HEE Quality Domain 2 Educational Governance and Commitment to Quality	Requirement Reference Number
2.8	**Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including HEE and Education Providers).** The Director of Medical Education (DME) stated that significant work had been done across both sites and action plans had been put in place to address the issues raised by the GMC NTS 2021. The DME highlighted that there were significant rota gaps and that the Trust was aware of these and was working to address them, but that this was difficult in the face of national shortfalls in medical staffing, staff sickness and self-isolation requirements. The Trust had invested in rota coordinator roles to ensure there were staff dedicated to anticipating and managing rota gaps as far as possible. It was acknowledged by the review panel that not all training posts had been filled, particularly at IMT3 level, where far more trainees had indicated that they would take up posts than had actually done so. The review lead noted that other trusts had had success recruiting doctors through the medical training initiative (MTI) and that HEE could assist the Trust with workforce transformation and planning non-medical roles to cover some aspects of the work. The Trust representatives advised that the physician associate (PA) training programme had been expanded and that the PAs gave good support on the wards. However, because they could not prescribe medication or order ionising radiation, the amount of tasks PAs could take over from junior doctors was limited. PAs also did not work weekends, although the Trust was considering changing this. Prior to the COVID-19 pandemic there had been plans to increase the number of prescribing pharmacists at the	

	Trust but the review panel heard that there was less pharmacist presence on the wards since the pandemic began and that recruitment was also a challenge for the pharmacy teams. The supervisors were divided over whether additional PAs would positively impact on trainees' experience, with some suggesting that having more PAs and non-medical staff on the wards would allow the trainees more time to access learning opportunities, and some disagreeing due to the difference in remits and competences.	

HEE Standard	HEE Quality Domain 3 Developing and Supporting Learners	Requirement Reference Number
3.1	**Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.** The review panel was informed that the Trust had conducted an internal survey of foundation trainees which found that 40% of F1s had considered leaving medicine. The Trust had put a wellbeing programme in place and repeated the survey, which found that 65% of foundation trainees felt the programme had had a positive impact on them. The Trust planned to develop this further to better support other trainee and staff groups. The supervisors described the wellbeing sessions for junior doctors which covered a range of topics, from sessions on stress and unwinding with a clinical psychologist, to sessions on dealing with death and dying, which some trainees were not very familiar with prior to the pandemic. The supervisors remarked that they had seen junior doctors leading on audits, quality improvement projects and leading on resuscitation teaching for their colleagues following participation in the wellbeing programme. The Trust management representatives stated that a lot of work had been done to improve communication and feedback channels between consultants and trainees in order to create a positive training environment.	
3.5	**Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.** **QEH** The F1s at QEH reported that they were supervised and supported by either consultants or other junior doctors both in and out of hours. The F1s were unsure whether there was a dedicated Hospital at Night team.	Yes, please see M3.5a

	The IMTs found the level of consultant supervision to be variable between departments. For example, they cited geriatrics and respiratory medicine as having good levels of supervision, but described responding to calls in other areas where the junior doctors and nurses on the wards did not know who the on-call consultant was or how to contact them. The review panel heard that there had been instances of this overnight, where the switchboard had also not known who the on-call consultant was for a given specialty and trainees had had to contact other consultants to ask them which of their colleagues was on-call. The IMTs advised that in some areas, such as the intensive care unit, it was standard practice for the on-call consultant to contact them at the start of a night shift, but that this did not happen in medicine. **UHL** The IMT and higher trainees advised that there were no consultant ward rounds at weekends on the medical wards, but that there was a post-take consultant-led round. It was reported that wards varied in terms of their level of consultant presence, with some having daily consultant rounds during the week, and others having them twice a week. The review panel heard that an additional higher trainee-level doctor had been added to the general medicine wards, which had improved the frequency of ward rounds. While trainees reported knowing who the on-call consultant was for their own specialty, they recounted instances where they had found it difficult to know who to contact for advice from other specialties, for example stroke medicine. They advised that on occasion it had taken nearly an hour to find out which consultant was on-call for a particular specialty and get their contact details. The trainees were not aware of any cases of patient harm caused by this, but felt it was a risk.	Yes, please see M3.5b
3.6	**Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.** The IMT and higher trainees nearly all had ESs and CSs, although in some cases trainees at UHL reported that their CS was based in a different specialty or that one person covered both roles. At QEH the trainees had been assigned ESs from outside their placement areas.	
3.8	**Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.** **QEH**	

	The F1s did not report being asked to perform tasks beyond their level of competence. Some had acted up as F2s while on call but did not raise any concerns around this. The trainees advised that the F2 or core-level trainee held the main referral bleep, so most tasks were assigned to the F1 trainee through them. The review panel was informed that there was good support from the phlebotomy team on most wards and that the F1s had not had any issues ordering laboratory or radiology investigations.	
3.9	**Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.** **QEH** The F1s who attended the review had all had induction to the Trust and the clinical areas where they worked. Some described receiving supplementary materials like induction booklets and none felt that topics had been missed from their induction. The IMTs suggested that an IMT3 induction would be very useful in order to introduce trainees to the medical registrar role. There was an overall IMT induction but they described this as being more aimed at IMT1 and IMT2. **UHL** The IMTs at UHL agreed that a IMT3 induction would be helpful, particularly as this was a new programme. The supervisors at UHL advised that they had looked at the GMC NTS results for foundation training and had worked to improve the trainees' induction. Each trainee had a Trust-level, local-level and foundation-specific induction, and the TPDs advised that they met each trainee at the start of the year to establish expectations, discuss the curriculum and ensure the trainees were aware of the learning opportunities available. The TPDs also reported that they provided guidance to supervisors around specific considerations for foundation trainees and their curriculum.	Yes, please see M3.9

HEE Standard	HEE Quality Domain 4 Developing and Supporting Supervisors	Requirement Reference Number
4.1	**Supervisors can easily access resources to support their physical and mental health and wellbeing.** The supervisors felt that there were good relationships between the consultants and between consultants and junior doctors, and that the pressure of working during the COVID-19 pandemic had made most of the doctors more aware of supporting one another. The supervisors were complimentary about the Trust and	

	departmental wellbeing programmes. It was acknowledged that most of the wellbeing offers so far had focused on junior doctors and that, while there was good informal support among the consultant body, more formalised wellbeing resources for consultants would be welcome. A monthly teaching session had recently been introduced for supervisors, which covered topics around training and education, as well as information around the GMC and revalidation.	
4.3	**Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, HEE).** One supervisor explained that they had recently attended an external supervision course which the Trust had funded. Others noted that they had access to different internal courses around topics such as coaching.	
4.5	**Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.** Some supervisors felt that the trainees' expectations around working hours, teaching time and development time were unrealistic and reduced their time with their supervisors. They said that the time spent out of the clinical area made it harder for supervisors to work with their trainees and provide support. It was acknowledged that most of these requirements came from HEE, the GMC and the relevant curricula, but it was also suggested that expectations between the Trust and trainees around development time needed to be clarified.	
4.7	**Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.** The supervisors reported that they had separate educator appraisals every three years. The review panel heard that new supervisors were well supported with a package of training which included sessions on education, processes such as revalidation, and equality, diversity and inclusion. This programme was described as being very well planned and useful.	

HEE Standard	HEE Quality Domain 5 Delivering Programmes and Curricula	Requirement Reference Number
5.1	**Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.** **QEH** The F1s stated that they were generally able to perform procedures and access learning opportunities but that in certain areas, such as acute medicine, there was often not time for this. They suggested that this was due to a lack of staffing leading to high workloads rather than a particular issue with the placement. The IMTs agreed that there were good learning opportunities available due to the clinical demographics of the patient cohort, but that it could be difficult to access these. Some trainees had been unable to get to clinics, due to a combination of high workload on the wards and a lack of allocated clinic rooms for trainees to see patients. In these cases, trainees had spent time in ambulatory care, but they did not think this was sufficient to meet their curricular requirements. **UHL** The IMTs at UHL reported that they had a rostered clinic week during the year, although some trainees had experienced difficulty accessing clinics in certain specialties such as geriatric medicine.	Yes, please see M5.1
5.6	**Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.** The F1s estimated that they had attended between three and five hours of teaching each during the month before the review. These included general foundation teaching and departmental teaching, though trainees advised that not all clinical areas offered departmental teaching sessions. It was noted that the general teaching sessions were recorded so that trainees could refer back to them, and that the sessions were alternately held at QEH and UHL, with trainees at the other site accessing the sessions remotely. It was suggested that it would be useful to know in advance how long teaching sessions were due to be so that trainees could inform their teams of how long they were likely to be off the wards. The F1s reported that they were asked for feedback after each teaching session. The IMTs and higher trainees at UHL advised that there was weekly teaching and pan-London teaching available, but that it was difficult to leave the wards to attend due to workloads. At QEH the IMTs and higher trainees reported that they attended	Yes, please see M5.6

	teaching at St Thomas' hospital every two or three weeks. IMT teaching was not bleep-free at either site. IMTs at both sites noted that there was a single simulation skills session planned for March 2022 and that this would be one of the main opportunities to get their Direct Observation of Procedural Skills (DOPS) signed off. Some trainees had been asked to perform procedures and had to refuse as they had not undergone simulation skills training yet. The trainees suggested that simulation training could be put to much better use, for example in human factors sessions and preparing trainees to act up to the next level of training. The trainees pointed out that simulation skills were a key part of the IMT curriculum.	
HEE Standard	**HEE Quality Domain 6 Developing a sustainable workforce**	**Requirement Reference Number**
	Not discussed at this review	

Report Approval

Quality Review Report completed by	Louise Brooker Deputy Quality, Patient Safety and Commissioning Manager
Review Lead	Geeta Menon Postgraduate Dean, South London
Date signed	10 May 2022

HEE Authorised Signature	Geeta Menon Postgraduate Dean, South London
Date signed	10 May 2022

Final Report submitted to organisation	12 May 2022