NHS
Health Education England

Review of Northern Lincolnshire NHS Foundation Trust *(Postgraduate Medical)*

Quality Assurance of Local Education and Training Providers

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Guidance

From 1 April 2015 Health Education England, working across Yorkshire and the Humber (HEE YH) introduced a new quality function and team structure. The quality function is responsible for leading and overseeing the processes for the quality assurance and quality management of all aspects of medical and non-medical training and education. Our aim is to promote an ethos of multi-professional integrated working and believe that improving quality in education and training is at the heart of delivering outstanding patient care.

HEE YH invests £500 million every year on commissioning a wide range of education on behalf of local and national health systems. It has a duty to ensure that the Education Providers delivering this education provide a high standard of professional education and training.

Standards are built around 5 core themes:

Theme 1	Supporting Educators
Theme 2	Supporting Learners
Theme 3	Learning Environment and Culture
Theme 4	Governance and Leadership
Theme 5	Curricula and Assessment

1. Details of the Review

Visit Date(s)	12 and 13 April 2016

Visit Panel / team

Day One

Name	Role
David Eadington (Visit Chair)	Deputy Postgraduate Dean
Paul Renwick	Head of School – Surgery
James Thomas	Lead for Quality Assurance – General Practice
Alison Smith	Head of School – EM
Teresa Dorman	Associate Postgraduate Dean
Michael Nelson	Associate Postgraduate Dean
Gavin Anderson	Deputy Foundation School Director
Jackie Tay	Head of School – O&G
Tom Farrell	Deputy Head of School – O&G
Julie Platts	Quality Manager
Sarah Walker	Quality Manager
Vicky Jones	Quality Coordinator
Emily Downes	Programme Support Coordinator

Day Two

Name	Role
David Eadington (Visit Chair)	Deputy Postgraduate Dean
Peter Hammond	Head of School – Medicine
Jackie Tay	Head of School – O&G
Maya Naravi	Head of School – EM
Jane Allen	Training Programme Director – O&G
Craig Irvine	Deputy Foundation School Director
Julie Platts	Quality Manager
Sarah Walker	Quality Manager
Ryan Holmes	Programme Support Administrator

2. Summary of findings

There was excellent engagement from the Trust, trainees and trainers and the visit was well organised. Video conferencing for the surgical panel was a complete success. Although the 'Dr Who' campaign posters were on display there were still numerous references to SHOs throughout the two days from trainers and trainees.

The Trust has done a lot of work to respond to previous regulator concerns, the most recent CQC report findings and the Trust response, are noted. The panel heard about the Healthy Lives, Healthy Futures (HLHF) initiative, and the plans for a more integrated health economy (which will need to be coordinated in future with the forthcoming Humber, Coast, Vale STP work).

There are major staffing pressures on some services (particularly Medicine and Emergency Medicine), and issues were raised around whether the number of inpatient medical beds in the Trust, on two sites, can be supported by the junior staffing available. There were several comments made about the potential for service reconfiguration on one site avoiding duplication and improving the training experience. With HLHF in mind, it is not clear how commissioners consider the implications of limited staffing levels on service delivery in their future planning. In terms of surgical specialties it will also be necessary for the Trust to demonstrate how their working practices are coordinated with the tertiary centres for trauma, vascular surgery, cardiac surgery and cancer so that trainees are kept fully aware of transfer and repatriation policies.

The importance of service configuration was reinforced by reports in both surgery and medicine of poor patient flow management, with unnecessary admissions via the emergency department due to lack of senior triage, a lack of systematic weekend ward rounds on base wards (Medicine), and delayed discharge due to lack of senior clinical management decision making. Given the long term medical staffing pressures facing the Trust we were surprised that Trainers were unaware of there being a Trust strategy for alternative workforce development. Clinical engagement is essential for this to work, and the Trust should urgently consider developing a robust strategy to provide alternative workforce solutions at both Diana Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH), or publicise the plan better if it already exists.

It was apparent that the Director of Medical Education receives inconsistent support from College Tutors to address concerns raised at previous quality visits. Dr McNeil and the postgraduate team deserve praise for making great efforts to improve education and training, and they need cooperative support from all the clinical management teams. **There is a fundamental tension in effectively delivering educational and managerial roles, and such positions should always be held by separate individuals to avoid either real or perceived conflicts of interest.**

Incident Reporting/Revalidation; the medical revalidation process has been fully operational for three years. The Trust has an improving, but still relatively low, reporting rate for involvement of trainees in clinical incidents and complaints - 7.6 reports/100 trainees (HEE YH range 0.15 -29.6). The improvement is welcome, but the inverse correlation that exists between reporting rates and litigation costs was recently discussed in the Revalidation Liaison Group. Reporting rates are a surrogate marker of a Trust's stance on transparency and duty of candour, and of how the Trust recognises, manages and learns from clinical incidents.

3. Good Practice and Achievements

- Patient Safety Junior Doctor Forums with Dr McNeil described by trainees as being genuinely interested in their views and ideas.
- The PGME team were described as 'supportive, knowledgeable and helpful'
- Foundation Trainee induction in Emergency Medicine
- Dr Malik and Dr Banerjee were mentioned by name as being particularly supportive.
- Electronic records for the patient observations (Medicine)

Specialty findings

Obstetrics and Gynaecology

There were no serious concerns identified in either department. Foundation and core trainees at both SGH and DPOW reported receiving good training, with plenty of opportunities to attend theatre and clinic. The Trust and departmental induction both include hands on practical training and were well received. The trainees felt well supported by senior colleagues including during out of hours shifts. Trainees would recommend the department to a colleague with one trainee planning to return to the Trust in the future as an ST3 if possible. However, local teaching was described as 'patchy' due to cancellations, although this had improved since January 2016.

Higher trainees reported that teaching on Wednesdays was a good opportunity for them to present to their colleagues and valued the Friday teaching organised by Consultants, for example laparoscopy simulation sessions. The trainees are able to review their own patients in clinic and feel well supported by Consultants if they need to seek advice. The higher trainees reported that midwives are supportive and will alert a trainee if there are cases that would be beneficial for them to undertake. There was particular reference to the excellent examination preparation support that was provided.

There are four handovers per day at both sites - this could be seen as time consuming but the overall feeling, particularly at DPOW, was that this was robust and valuable.

There were some issues in terms of breadth of experience, for example in scanning and theatre experience at SGH. It was felt that the introduction of only one Consultant being on call in the daytime could free up the middle grade trainees to better access educational opportunities. The Head of School for O&G will discuss this suggestion with the College Tutor, TPDs and DME.

Emergency Medicine

There were no serious training concerns were raised, although the sustainability of full A+E services on both sites is a major challenge for the Trust, particularly at Scunthorpe where there are only ~3.5 substantive senior staff.

Trainees report that the Foundation trainee induction is exceptional. The trainees highlight that the department is very friendly with good access to clinical and educational supervision. There is weekly teaching that is well organised. Trainees are always granted leave to attend regional teaching and all those interviewed would recommend the posts to a colleague and be happy for family and friends to be treated in the unit.

However, there were reports of locum colleagues being of variable quality, sometimes affecting the clinical opinions provided to trainees. It is recommended that the Trust review the educational supervisor responsibilities to ensure that their time is spent as effectively as possible. In addition the trainees on the first tier rota would like input into rota management so they can take more responsibility. There was also a suggestion from trainees that there should be a clearer process for identifying the lead doctor responsible for the resuscitation team. .

Surgery

The Trust and Departmental inductions generally work well for the trainees. Consent taking/training is well managed and higher trainees are positive about the rota. Trainees were complimentary about the new patient safety trainee forums. The morning handover is well managed and includes surgical subspecialties.

In general trainers thought the move towards recognition of trainer roles, job planning and appraisal has improved. Trainers felt that they provide a good training environment.

The panel have noted in condition 3 that FY2 trainees in Surgery continue to have no consistent resident senior support out of hours. The trainees are leading trauma calls and making decisions outside of their level of competence. T**his is a serious and longstanding concern, and if it is not resolved rapidly it could be recommended to the General Medical Council for escalation to their enhanced monitoring process.**

Medicine

Trainees described the department as a great place to train in medicine with wide experience of cases – though workload is high and some felt it was "learning a lot the hard way". The Trust induction was comprehensive and foundation doctors get good support from senior colleagues. It was noted that phlebotomy support has been addressed and is no longer a problem.

Core Trainees are well supported by nursing staff. At Scunthorpe Foundation doctors would recommend the posts because it is a good experience, and would by happy for family and friends to be treated in the department.

The Diabetes & Endocrinology post at DPOW was praised for providing a good training experience. The Radiology, journal club and CMT teaching is of high quality when trainees are able to attend and trainees are able to access senior support in terms of WBA completion.

It was noted that only patchy progress has been made on the 2015 condition about CMT clinic attendance. Trainers felt that some of this was related to poor time management by trainees. The Rheumatology core trainee had attended 30 outpatient clinics since commencing in post, illustrating that progress is possible, and this was deemed to be a very valuable learning experience. Dr Malik was described as proactive in allocating trainees to clinics and reassures them that the ward work will be managed whilst they are away. Gastroenterology has made some progress, but no other specialty group were receiving enough outpatient experience. There is also a structural problem with limited availability of rooms in outpatients that also needs to be examined urgently.

It was confirmed that locum doctors are no longer being allocated as Educational Supervisors to trainees. Nursing staff were generally praised and trainees value working in a multiprofessional team with the stroke nursing staff described as 'fantastic'. The Medical Assessment Unit (Scunthorpe) was reported to work well with a large morning handover ward round with educational input that was valued by the trainees.

It proved very difficult to understand the detail of consultant working patterns for inpatients, beyond the fact that there are MAU ward rounds and acute physician sessional working. It appeared from discussions that only one specialty (Haematology) has a named consultant covering all specialty inpatients at any one time. In others there are multiple smaller consultant ward rounds, often at odd times that do not provide efficient use of time for the junior staff. It was noted that this has been mentioned in previous quality visit reports. Trainees were not aware of clear plans for cross cover of inpatients within teams during annual leave, and there were reports of some patients going for lengthy periods without consultant review. Some consultants are viewed as making too much use of Board Rounds rather than seeing their patients. The conclusion was that inpatient care was regularly being delegated too far down the hierarchy, aggravating patient flow and decision making issues. The panel would recommend consideration of a wide ranging review of how Consultant working patterns might be modified to improve both service efficiency and training delivery. We formed the impression that too many physicians tend to work as individuals rather than as part of a team and, again, this has been highlighted in previous quality reports.

Out of hours intensity is high for base ward cover staff. At weekends there is very limited senior presence, beyond the MAU cover. The sense of overstretch was reinforced by the fact that Core Medical Trainees would not recommend for colleagues neither would they recommend the Trust to family and friends for medicine. An SAS doctor was named by several trainees as consistently not providing them with adequate clinical supervision and this was reported to the DME. There were also instances of trainees not being provided with pastoral support when they were involved in serious Incidents or inquests.

The panel noted in condition 9 that at SGH Cardiology trainees reported that they do not have clinics rostered and it is difficult for them to attend. At DPOW most core trainees did not have the opportunity to attend outpatient clinic and review patients. T**his is a serious and longstanding concern, and if it is not resolved rapidly it could also be recommended to the General Medical Council for escalation to their enhanced monitoring process.**

Conditions

The following conditions were identified at the visit:

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.13 Induction)**	Organisations must make sure learners have an induction for each placement that clearly sets out • their duties and supervision arrangements • their role in the team • how to gain support from senior colleagues • the clinical or medical guidelines and workplace policies they must follow • how to access clinical and learning resources As part of the process learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.	
HEYH Condition Number	1 (HEYH Ref: 16/0033)	
LEP Site	SGH	
Specialty (Specialties)	Surgery	
Trainee Level	All	
Concern	Trainees are not always provided with access to essential IT at the start of their post	
Evidence for Concern	Trainees reported that PACs and dictation system training is provided by one individual and trainees reported it takes up to 4 weeks to train everyone. In the interim trainees are sharing user names and passwords.	
Action	Provide trainees access to IT before they are due to begin work.	**August 2016**
Evidence for Action	Confirmation that all trainees are provided with access to relevant IT at the start of their post.	**August 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.8 Clinical Supervision)**	Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must always have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.	
HEYH Condition Number	2 (HEYH Ref: 16/0034)	
LEP Site	SGH and DPOW	
Specialty (Specialties)	Surgery	
Trainee Level	Foundation and Core	
Concern	Trainees are often expected to provide clinical care without access to appropriate support	
Evidence for Concern	It was reported that the Site management team and senior nurses in the Emergency Department are making decisions about patient admissions to avoid breaching 4 hour waiting time targets despite contrary advice from trainees (it was noted by the panel that this has been an ongoing problem for many years). An example was given of a patient with a suspected hip fracture who did not have an x-ray before the 4 hour waiting target so was admitted unnecessarily overnight (there was no fracture). The trainees feel there is a lack of senior support in the ED to ensure that surgical trainee decisions are upheld in terms of patient management despite pressure from nursing staff and managers.	
Action 1	Provide trainees with senior support for their surgical clinical management decisions	**May 2016**

Action 2	Discuss the perceptions trainees have regarding the lack of support and take appropriate action to address the trainees' concerns. Trainees must be reassured that their concern has been addressed. Review trainee perceptions after 3 months.	**May 2016**
Evidence for Action 1	Copy of senior cover rota for surgical trainees working in the Emergency Department	**Immediate**
Evidence for Action 2	1. Confirmation that discussion has taken place 2. Copy of action plan to address concerns 3. Copy of report from trainee review	**May 2016** **June 2016** **July 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement (R1.8 Clinical Supervision)	Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must always have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.	
HEYH Condition Number	3 (HEYH Ref: 16/0035)	
LEP Site	SGH and DPOW	
Specialty (Specialties)	Surgery	
Trainee Level	FY2	
Concern 1	Foundation trainees are not provided with consistent on-site support from a senior colleague out of hours.	
Concern 2	Trainees are expected to carry out duties, such as leading trauma calls, which are not appropriate for their stage of training	
Evidence for Concern	FY2 trainees in Surgery have no consistent resident senior support out of hours. They are leading trauma calls and making decisions outside of their level of competence.	
Action 1	Foundation trainees MUST have immediate access to on-site support from a middle grade surgeon or Consultant (**not the Medical Registrar, who is already managing a large number of patients).**	**June 2016**
Action 2	Provide trainees with clear guidance and an escalation policy that identifies who should be contacted	**Departmental Induction for August 2016 intake**
Action 3	Discuss the perceptions trainees have regarding the lack of support and take appropriate action to address the trainee's concerns. Trainees must be reassured that their concern has been addressed. Review next trainees' perceptions after 2 months.	**September 2016**
Evidence for Action 1	Copy of resident senior cover rota.	**August 2016**
Evidence for Action 2	Copy of guidance/escalation policy.	**August 2016**
Evidence for Action 3	1. Confirmation that discussion has taken place 2. Copy of action plan to address concerns 3. Copy of report from trainee review	**October 16** **June 2016** **October 16**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

Resources	http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf http://www.yorksandhumberdeanery.nhs.uk/media/501652/201404v2Trainer%20Accreditation%20Policy.pdf http://www.gmc-uk.org/Final_Appendix_4___Guidance_for_Ongoing_Clinical_Supervision.pdf_53817963.pdf	
GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.14 Handover)**	Handover** of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice. ***Handover at the start and end of periods of day or night duties, every day of the week.*	
HEYH Condition Number	4 (HEYH Ref: 16/0036)	
LEP Site	Scunthorpe	
Specialty (Specialties)	Surgery	
Trainee Level	All	
Concern 1	Handover is not attended by appropriate members of staff for Urology and ENT.	
Concern 2	Handover is not supported by appropriate documentation.	
Concern 3	Handover for ENT and Urology is not appropriately led.	
Evidence for Concern	It was reported that morning handover general works well. However, there is only one Urologist on call (for both sites) and trainees have difficulty knowing who takes responsibility for urgent cases as there is no formal system in place. There is also a potential to miss reviewing urology patients and it was noted this has been a problem over several years. There is a similar problem with handover of ENT patients as sometimes there are no ENT Consultants or trainees available and again these patients could get missed. ENT patients are often admitted to outlying wards and so it is particularly important that a robust system is in place to manage their inpatient care. The panel understood that the Surgery department do not use the web portal (Web V) for their handover system. There is a computer generated list but this cannot be viewed on more than one computer simultaneously so multiple versions are sometimes created and as such patients can get missed for ward round review.	
Action 1	Introduce a handover system that meets College or Specialty standards.	**July 2016**
Action 2	Make appropriate changes to working arrangements to allow relevant staff to attend handover.	**July 2016**
Action 3	Introduce a reliable method of documenting the handover discussion, actions and job list. If this involves IT, there must be easy access in all clinical areas.	**July 2016**
Action 4	Appoint an appropriate senior member of staff from ENT and Urology to lead the handover of their patients.	**July 2016**
Action 5	Evaluate effectiveness of handover.	**October 2016**
Evidence for Action 1	1. Copy of handover policy 2. Confirmation that staff training has been completed that ensures all the handover team understand the handover process and what good handover of patients involves. 3. Confirmation that handover has been introduced 4. Confirmation that the handover policy has been explained to new starters	**- July 2016** **- August 2016** **- August 2016** **- August 2016**
Evidence for Action 2	Summary of revised rotas/work arrangements.	**July 2016**
Evidence for Action 3	1. Copies of handover documentation	**- July 2016**

	2. Description of e-handover system	**- July 2016**
Evidence for Action 4	Copy of process authorising arrangements for the leadership of handover for ENT and Urology.	**July 2016**
Evidence for Action 5	Copy of the handover system evaluation.	**December 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	
Resources	bma.org.uk/-/media/files/.../safe%20handover%20safe%20patients.pdf www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-1-handover.pdf	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.12 Rotas)**	Organisations must design rotas to: • make sure learners have appropriate clinical supervision • support doctors in training to develop the professional values, knowledge, skills and behaviours (KSB) required of doctors working in UK • provide learning opportunities that allow doctors in training to meet the requirements of the curriculum and training programme • give learners access to ES • minimise the effect of fatigue and workload	
HEYH Condition Number	5 (HEYH Ref: 16/0037)	
LEP Site	SCH and DPOW	
Specialty (Specialties)	Medicine	
Trainee Level	All	
Concern 1	Trainees are provided with duty rotas which are very difficult to modify.	
Concern 2	Trainees are provided with rotas, which do not provide them with sufficient opportunities for rest and recreation.	
Evidence for Concern	At both sites rota coordinators appear to make it difficult for trainees to take leave. If trainees wish to book leave they need to obtain up to 3 signatures and even then it may be refused permission. It was reported that a core trainee had an exam leave request refused. When trainees do have leave approved it may then be subsequently cancelled at short notice or they can only book individual days and not blocks of leave. There are reports of trainees being informed by rota coordinators that their leave approval depends on them undertaking certain out of hours' shifts in return. The Trainees interviewed would support being told when they can take their allocated annual leave in fixed blocks rather than not having leave at all. At DPOW trainees reported the rota coordinator raises understaffing issues at the morning handover and trainees feel under pressure to agree to act as locums. Trainees have sometimes flagged up potential rota gaps several days before, and feel with more planning some of the 'last minute panic' to fill gaps could be avoided. Trainees told the panel that they have offered to be involved in rota coordination management but this has not been accepted.	
Action 1	Work with trainees and rota organisers to ensure that rotas are provided with sufficient notice and flexibility and fairly distribute clinical duties and responsibilities.	**July 2016**
Action 2	Work with trainees and educational supervisors to develop rotas that have an appropriate balance between the needs of patient safety and clinical service and the trainee's legitimate expectations for teaching, training, feedback, rest and recreation.	**July 2016**
Action 3	Review the impact of the introduction of new rota arrangements.	**November 2016**
Evidence for Action 1 &2	Copies of rotas.	**July 2016**
Evidence for Action 2	Summary of the impact of any changes made.	**December 2016**

RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	
Resources	http://bma.org.uk/practical-support-at-work/contracts/juniors-contracts/rotas-and-working-patterns http://careers.bmj.com/careers/advice/view-article.html?id=20001163#	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.15 Experience)**	Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.	
HEYH Condition Number	6 (HEYH Ref: 16/0038)	
LEP Site	Scunthorpe	
Specialty (Specialties)	Medicine	
Trainee Level	All	
Concern	The posts offer trainees too little experience to meet curriculum requirements.	
Evidence for Concern	If trainees need an ultrasound guided intervention (ascitic tap, pleural drainage) then a Radiologist will carry this out. Trainees are not encouraged to become involved, and feel disengaged with the process.	
Action	Review, with the involvement of trainees, the opportunities for a broader educational experience.	**July 2016**
Evidence for Action	Copy of review summary and action plan to introduce new educational opportunities.	**November 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.7 Staffing)**	Organisations must make sure that there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating learning opportunities.	
HEYH Condition Number	7 (HEYH Ref: 16/0039)	
LEP Site	SGH and DPOW	
Specialty (Specialties)	Medicine	
Trainee Level	All	
Concern	Trainees report that there are insufficient staff on duty to meet rota requirements	
Evidence for Concern	Trainees reported being moved from ward to ward at short notice that does not allow for either effective continuity of patient care or a valuable training experience.	
Action	Review staffing levels and develop an action plan to address the deficiencies.	**July 2016**
Evidence for Action	Copy of review and action plan.	**October 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**
Requirement **(R1.13 Induction)**	Organisations must make sure learners have an induction for each placement that clearly sets out • their duties and supervision arrangements • their role in the team • how to gain support from senior colleagues • the clinical or medical guidelines and workplace policies they must follow • how to access clinical and learning resources As part of the process learners must meet their team and other health and social care professionals they will be

	working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.	
HEYH Condition Number	8 (HEYH Ref: 16/0040)	
LEP Site	SGH and DPOW	
Specialty (Specialties)	Medicine	
Trainee Level	Foundation and Core	
Concern	Trainees are not provided with a relevant introduction to work in the clinical area. They are not provided with essential guidance on the management of the important or common conditions they are expected to manage as soon as they take up post.	
Evidence for Concern	At SGH departmental induction was said to be 'patchy'. At DPOW departmental induction consists of Consultants attending the Trust induction and providing a 20 minute talk about their department. However, the trainees did not feel this fully equipped them to start work and felt they 'had to pick the job up as they went along' and described feeling under a large amount of pressure.	
Action 1	Provide all trainees with a relevant departmental, specialty or ward induction/orientation.	**August 2016**
Action 2	Evaluate the effectiveness of departmental induction.	**August 2016**
Evidence for Action 1	Copy of departmental induction programme.	**August 2016**
Evidence for Action 2	Copy of induction evaluation and plans for modifications (if indicated).	**August 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	
Resources	http://careers.bmj.com/careers/advice/view-article.html?id=20000724	

GMC Theme	**DEVELOPING AND DELIVERING CURRICULA AND ASSESSMENT**	
Requirement (R5.9a Posts)	Postgraduate training programmes must give DiT Training posts that deliver the curriculum and assessment requirements set out in the approved curriculum.	
HEYH Condition Number	9 (HEYH Ref: 16/0041))	
LEP Site	SGH and DPOW	
Specialty (Specialties)	Medicine	
Trainee Level	Core	
Concern 1	Whilst the post offers the potential for a broad range of experiences trainees are unable to take advantage of them due to their clinical duties	
Concern 2	The posts offer trainees with too narrow an experience to meet curriculum requirements.	
Evidence for Concern	At SGH Cardiology trainees reported that they do not have clinics rostered and it is difficult for them to attend. At DPOW most core trainees did not have the opportunity to attend outpatient clinic and review patients.	
Action	Review and amend trainee work schedules to allow them access to outpatient clinics	**July 2016**
Evidence for Action	Copy of new timetables identifying outpatient clinic opportunities	**October16**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

GMC Theme	**DEVELOPING AND DELIVERING CURRICULA AND ASSESSMENT**

Requirement (R5.9a Posts)	Postgraduate training programmes must give DiT Training posts that deliver the curriculum and assessment requirements set out in the approved curriculum.	
HEYH Condition Number	10 (HEYH Ref: 16/0042)	
LEP Site	SGH and DPOW	
Specialty (Specialties)	Medicine	
Trainee Level	Core	
Concern	The posts in offer trainees with too few opportunities for PACES preparation	
Evidence for Concern	There was concern expresses that PACES preparation is not consistently provided. It is recognised there may not be enough trainees at one time to develop a 'programme' but more personal preparation should be developed.	
Action	Develop either a PACES preparation training plan or individualised training plan.	**July 2016**
Evidence for Action	Copy PACES preparation programme/individualised plans	**October 16**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**
Requirement (R1.8 Clinical Supervision)	Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must always have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.
HEYH Condition Number	11 (HEYH Ref: 16/0043)
LEP Site	SGH and DPOW
Specialty (Specialties)	Medicine
Trainee Level	Foundation and Core
Concern 1	Trainees are often expected to provide clinical care without access to appropriate support
Concern 2	Trainees do not know who to contact when seeking advice on clinical care for patients, or receive contradictory advice.
Concern 3	Trainees are expected to carry out duties which are not appropriate for their stage of training
Evidence for Concern	At both sites there is a shortage of senior cover on the wards with clinical management decision making sometimes being delegated to F1 level. Foundation trainees describe managing patient care for several days without senior review. The trainees report that on occasions senior colleagues working in AMU are unapproachable when asked to discuss issues about ward-based patients. Core Trainees do not feel well supported by middle grade doctors and Consultants. The described feeling under pressure and stressed as they regularly have to track down a senior colleague for advice. The trainees had specific patient safety concerns about outlying patients who are admitted to wards such as the paediatric assessment unit due to bed shortages. An example was provided at DPOW of an elderly patient who became acutely sick but did not have a formal escalation plan. The trainee was told to continue with IV antibiotics but the patient later died. There were also instances reported of Foundation trainees being asked to act up to CT level on the rota. This may be an acceptable opportunity for a successful senior F2 trainee into a CT1 role, but must never be applied to F1 trainees.

	Foundation trainees (F1 and F2) reported working out of hours (weekdays) and being solely responsible for all base medical wards, due to the CT trainee being called to MAU to cope with front door pressures. Trainees are instigating management plans but these are not always being reviewed by a senior colleague. One trainee described feeling as he was 'on a road without an instructor' because of the lack of feedback on clinical decision making.	
Action 1	Provide trainees with a named clinical supervisor	**Immediate**
Action 2	Provide trainees with clear guidance and an escalation policy that identifies who should be contacted	**July 2016**
Action 3	Discuss the perceptions trainees have regarding the lack of support and take appropriate action to address the trainee's concerns. Trainees must be reassured that their concern has been addressed. Review trainee perceptions after 3 months.	**July 2016**
Evidence for Action 1	Copy of senior cover rota including • How many teams have one nominated Consultant responsiblefor all inpatients? • How many teams are providing a base ward visit/ward round at weekends (separate to MAU cover)?	**Immediate**
Evidence for Action 2	Copy of guidance and escalation policy.	**July 2016**
Evidence for Action 3	1. Confirmation of changes made to cover arrangements 2.	**Immediate** **September 2016**
Evidence for Action 3	1. Confirmation that discussion has taken place 2. Copy of action plan to address concerns 3. Copy of report from trainee review (next intake)	**Immediate** **June 2016** **September 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	
Resources	http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf http://www.yorksandhumberdeanery.nhs.uk/media/501652/201404v2Trainer%20Accreditation%20Policy.pdf http://www.gmc-uk.org/Final_Appendix_4___Guidance_for_Ongoing_Clinical_Supervision.pdf_53817963.pdf	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**
Requirement **(R1.9 Level of Competence)**	Learner's responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of supervision.
HEYH Condition Number	12 (HEYH Ref: 16/0044)
LEP Site	DPOW
Specialty (Specialties)	Respiratory Medicine
Trainee Level	Foundation
Concern	Trainees are sometimes expected to carry out clinical duties that are beyond the expected level of competence for their stage of training.
Evidence for Concern	At DPOW Foundation trainees are expected to remove chest drains. If trainees highlight they do not feel competent the nursing staff have expressed their disappointment and have, on occasion, commented that 'the F1s last year were better than you are'. The trainees also gave an example of being made to feel they should not leave the ward to go to teaching by nursing staff who have, on occasion, complained to a Respiratory Consultant

	about their absence. The trainees reported feeling undermined by the respiratory medicine nursing staff on the wards and feel pressured by them to work beyond their level of competence.	
Action 1	Investigate if trainees are expected to carry out tasks that they feel are beyond their current level of clinical competence without appropriate supervision. Investigate the instances reported of undermining by nursing staff.	**June 2016**
Action 2	Provide alternative arrangements for staff to carry out these duties or appropriate training and supervision that will allow them to safely complete them.	**June 2016**
Action 3	Confirm that alternative arrangements have been adopted.	**September 2016**
Evidence for Action 1	Summary of investigations.	**June 2016**
Evidence for Action 2	Summary of alternative arrangements or plans for supervision and training.	**June 2016**
Evidence for Action 3	Written confirmation that policy has been adopted.	**September 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.14 Handover)**	Handover** of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice. ***Handover at the start and end of periods of day or night duties, every day of the week.*	
HEYH Condition Number	13 (HEYH Ref: 16/0045)	
LEP Site	DPOW	
Specialty (Specialties)	Medicine	
Trainee Level	Foundation and Core	
Concern 1	Handover is not supported by appropriate documentation.	
Concern 2	Handover is not appropriately led in the evenings	
Evidence for Concern	Trainees reported ineffective handover in the evenings at 9.30 pm and on Fridays at 4.30 pm. There is a verbal handover that could result in one trainee having approximately 150 jobs to undertake over the weekend. As there is no formal written record some tasks are sometimes forgotten.	
Action 1	Introduce a handover system that meets College or Specialty standards.	**September 2016**
Action 2	Make appropriate changes to working arrangements to allow relevant staff to attend handover.	**July 2016**
Action 3	Introduce a reliable method of documenting the handover discussion, actions and job list. If this involves IT, there must be easy access in all clinical areas.	**July 2016**
Action 5	Appoint an appropriate senior member of staff from ENT and Urology to lead the handover of their patients.	**July 2016**
Action 6	Evaluate effectiveness of handover.	**October 2016**
Evidence for Action 1	1. Copy of handover policy 2. Confirmation that staff training has been completed3. confirmation that handover has been introduced	**- July 2016** **- August 2016**

	5. Confirmation that the handover policy has been explained to new starters	**- August 2016** **-** **- August 2016**
Evidence for Action 2	Summary of revised rotas/work arrangements.	**July 2016**
Evidence for Action 3	1. Copies of handover documentation 2. Description of e-handover system	**- July 2016** **- July 2016**
Evidence for Action 4	Copy of process authorising arrangements for the leadership of handover for ENT and Urology.	**July 2016**
Evidence for Action 6	Copy of the handover system evaluation.	**December 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	
Resources	bma.org.uk/-/media/files/.../safe%20handover%20safe%20patients.pdf www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-1-handover.pdf	

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