NHS

Health Education East Midlands

University Hospitals of Leicester NHS Trust

Outcomes Report

For healthcare, education and training

Report For:	University Hospitals of Leicester
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1. Executive Summary

Health Education East Midlands (HEEM) visited University Hospitals of Leicester NHS Trust on 2nd and 3rd October 2014. The visiting team heard directly from learners (including trainee doctors, student nurses and allied healthcare professionals) and those who deliver their education and training at the Leicester Royal Infirmary, Glenfield Hospital and the Leicester General Hospital. Evidence gathered prior to the visit determined which areas of the Trust HEEM focused on. This was a level 2 visit.

The Trust's Executive and Education Teams provided an overview of achievements, challenges and future plans in relation to both medical and non-medical education and training and also showcased good practice and improvement projects. This demonstrated the Trust's engagement with, and commitment to, education and training. Engagement with HEEM's new approach to quality management was also positive.

The visit was largely positive in outcome, especially in relation to the use of non-medical tariff funding and the support experienced by non-medical learners, mentors and new starters, which may be a model transferable to medical training. There were also pockets of good practice in some specialties, where service demands were treated as opportunities for learning rather than a barrier (for example, Respiratory Medicine).

In general, the Trust has made good progress in implementing HEEM's *East Midlands Multi-professional Quality Standards for local training and education providers.* However, there are some areas for improvement and also a few patient safety concerns (although none requiring escalation to the General Medical Council or Care Quality Commission). Most notably, the Trust must ensure that it has robust and sustainable plans in place so that staffing levels and service delivery models do not skew the service / training balance towards service to the detriment of curricula delivery. This is especially an issue for postgraduate medical education and training. HEEM recognises the significance of this challenge in the context of high patient throughput, recruitment difficulties (regionally and nationally) and reliance on the postgraduate medical workforce to deliver service (excluding consultants, nearly 90% of the medical workforce are doctors in training). HEEM welcomes the Trust's honesty in acknowledging its challenges and will work collaboratively to support improvement initiatives.

2: Introduction

Health Education East Midlands (HEEM) is the vehicle for providers and professionals, working as part of NHS Health Education England (HEE), to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public. The statutory Postgraduate Dean's role directly carries specific accountability on behalf of the General Medical Council (GMC) where education and training is delivered within employing organisations. In addition, because practice placements and training posts are critical to education quality and professional outcomes, there is a legal, tripartite relationship between the Higher Education Institutions, the placement / training post providers and HEEM through both the Education Contract and the Learning Development Agreement. This ensures that employers are held to account for the quality of any learning provision they are involved in across the healthcare workforce. To this end, HEEM has developed a multi-professional approach to its Quality Management Visits (QMVs) to Local Education Providers (LEPs) and has produced the *East Midlands Multi-professional Quality Standards for local training and education providers* against which to assess the quality of learning environments.

This is the first year of HEEM's new, multi-professional approach to visiting, and HEEM would like to thank University Hospitals of Leicester NHS Trust (UHL) for the positive way in which it has engaged with the new process. A collaborative approach was taken to determine the focus and level of visit. A conference call, involving both HEEM and Trust representatives, looked at evidence from a variety of sources, including the Trust's self-assessment document, the GMC's National Training Survey results and workforce intelligence, and a decision was taken to undertake a level 2 visit. There are 3 levels of visit and a level 2 visit indicates 'medium risk' - "… *there are risks to meeting the standards for Training and Education. This level of visit aims to understand where the risks are and provide support to reduce negative impact on learners and outcomes*".

The Trust is comprised of three main hospital sites – the Leicester Royal Infirmary (LRI), the Leicester General Hospital (LGH) and the Glenfield Hospital (GH). Over two days, visit teams met with a range of medical and non-medical learners and their supervisors / mentors across all three sites. Areas of focus included Anaesthetics, Cardiology, Clinical Oncology Gastroenterology, Haematology, Histopathology, Medical Microbiology and Respiratory Medicine. In addition, the Trust's Senior and Education Teams presented developments from the last visit, future initiatives and challenges. A showcase session was also held for the Trust to highlight areas of innovation and improvement projects in relation to both medical and non-medical education.[1]

In parallel to this visit, the new East Midlands Dental Dean and his team visited the dental department to review education and training arrangements. The outcome was positive and a summary of the findings is included within this report in Section 4 – 'Good Practice and Innovation'. A copy of the dental full will be sent separately to the Trust.

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[1]The pre-visit conference call had also identified Obstetrics & Gynaecology as an area of focus, but this session had to be cancelled at short notice due to unforeseen circumstances (hence this is an interim report). A separate visit to this specialty is planned and the visit report will be updated accordingly.

3: Progress since last year

The last Quality Management Visit to the Trust took place on 25th and 26th June 2013[2]. Areas of focus for that visit, which were selected again to be seen on this visit, included Anaesthetics and Obstetrics & Gynaecology (with the latter yet to be visited – see footnote on previous page). There were also Trust-wide issues raised in 2013, progress on which was able to be tested on this visit, plus other specific issues relating to learner groups we met with this year (for example, staffing in Clinical Oncology).

Educational governance

The Trust has reorganised its clinical directorates into seven Clinical Management Groups (CMGs). Within each CMG, an Education Lead has been appointed. This is a welcome development at it has the potential to further raise the profile of education and training within the Trust and enable CMGs, previously driven primarily by service targets, to also be performance managed in relation to the quality of the training each delivers (facilitated by the Trust's new Quality Dashboard). As these roles develop, HEEM is keen to understand how they engage with external bodies, such as HEEM's Postgraduate Specialty Schools and Royal Colleges. A strong commitment to support the new Education Leads from the Trust's senior team and from Service Leads was evident during the visit. The team was also pleased to hear about the Trust's Education Strategy and how there is a clear route for education and training issues to be regularly communicated to the Trust Board and Executive Workforce Board.

Recommendation

Consider how the new Education Leads can be embedded in UHLs educational and financial governance structures as well as engage and work with external educational stakeholders, including HEEM's Foundation and Specialty Schools and the Royal Colleges.

Educational resources

It has been a longstanding ambition of the Trust to enhance its educational facilities. At the last visit, and from the results of recent national training surveys, trainees provided consistently negative feedback about educational resources. The visit team was pleased to learn that construction work on the new library is underway, with the new facility opening in early 2015. The visit team was impressed by the plans for the library, which were presented at the showcase session.

Of course, educational resources are not just about physical learning space; e-learning resources and infrastructure are also key. This has been recognised by UHL and the Trust is enhancing access to electronic resources (for example, 'UpToDate' – the point-of-care clinical information resource). However, the Trust should be mindful that trainees need access to computers (or other electronic devices) to make the most of these resources.

[2] The 2013 visit focussed on postgraduate medical education only.

3: Progress since last year (cont'd)

Emergency Department

HEEM decided not to focus on Emergency Medicine at this visit due to the progress that has been made in delivering and sustaining high quality education and training within arguably the most challenging of service environments. The work of Dr. Acheson and his team is commended and initiatives implemented at UHL have attracted attention from elsewhere (for example Dr. Acheson has been invited to speak at the School of Medicine's Acute Medicine Education event) and are being rolled-out across the East Midlands. Dr. Acheson updated the visit team on developments at the showcase session and described future plans. HEEM will monitor, with interest, the impact of the planned extension of the Emergency Department.

Patient safety

At the last visit, the team was concerned about poor recognition of different training grades of junior doctors and what they could be expected to be capable of. As a result, there was a danger that some doctors were being asked to work beyond their competence. This was compounded by some Foundation Year 1 (FY1) trainees working on Foundation Year 2 (FY2) / Core Trainee (CT) resident on-call rotas. A system of colour-coded lanyards for trainee doctors, with information posters about levels of competence of each training grade, is now well established and has helped to address this issue. Also, all FY1 trainees have been removed from all FY2 / CT rotas.

Anaesthetics

During the 2013 visit, feedback indicated low morale, trainees feeling under-valued, a lack of team-working and little on-the-job learning. Feedback from this visit was more positive. Service pressures and tight rotas continue to impact on training as well as on consultants' abilities to coordinate and manage education and maximise training opportunities. However, there is a cohort of relatively new consultants in the department, which is committed to training and, coupled with the recent appointment of an Education Lead for the CMG, there are plans in place to improve the training environment and some evidence of improvement already (for example, trainees are no longer being pulled from training lists to cover service lists). HEEM was reassured that service leads will support initiatives to improve training, although sustainability in the face of onerous service demands will need to be closely monitored.

Of particular note, there was good engagement with the education and training agenda demonstrated by both educational and service leads, as well as praise from trainees for some excellent trainers, effective departmental induction and better coordination and management of training.

The trainees raised concerns about Trust induction failing to provide them with all the information they needed in a timely fashion prior to commencing work. Specifically, the trainees referred to IT logins, swipe access, ID badges and pay services, and felt this was a potential patient safety issue.

3: Progress since last year (cont'd)

Specific areas for improvement include better access to the Sim. Man for simulated training, the move to 1 in 8 rotas and more regular, consultant-led, departmental teaching sessions. However, the visit team notes that there are plans for a half-day teaching session (to rotate between the three hospital sites), while there is already a monthly, combined audit / mortality and morbidity meeting (also rotating between sites).

Requirement

Ensure more regular access to the Sim. Man. This is an issue extending to other specialties.

Requirement

Ensure all rotas are at least 1 in 8 within a timescale to be agreed with HEEM. This is currently a Royal College requirement.

Recommendation

Review the current departmental teaching opportunities and develop a timetable of formal teaching sessions. This may include the establishment of monthly, half-day teaching (in coordination with surgical colleagues so that lists are timetabled to facilitate the sessions), potentially drawing on the 'divisional day' model already established for Anaesthetics in the North of the East Midlands.

Requirement

The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed version of this report, that it has processes in place to ensure that all new starters in Anaesthetics have access to the information they need to work effectively and safely in clinical areas before they commence work in these areas.

Requirement

The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed report, that it has processes in place to ensure that all new starters have access to clinical systems on commencement at the Trust.

3: Progress since last year (cont'd)

Clinical Oncology

While at the 2013 visit, Clinical Oncology was not a focus, during a cross-specialty feedback session with trainees it was reported that the middle-grade tier in the department had previously been understaffed and that the resulting need to cross-cover service had impacted negatively on training. The trainees felt that this would be reflected in the 2013 GMC training survey (conducted April 2013), and indeed it was, with half of the indicator scores (at HST level) being negative outliers. However, at the time of the visit (June 2013), the trainees reported that staffing levels had improved and this had benefitted training.

It was of some concern that the 2014 GMC survey results again showed a number of negative outliers for this specialty and, primarily due to this, the specialty was a focus of the 2014 visit.

During this visit, trainees reported good access to formal teaching, appropriate senior supervision and, in general, a high quality training experience within the department. All of the trainees seen by the visiting team would be happy for friends or family to be treated in the department and would recommend the department as a place within which to train.

However, medical staffing levels had again been impacting negatively on training. In particular, trainees were being asked to cover gaps in the rota and this had hindered trainees' access to clinics. Trainees felt that this prevented exposure to some of the more interesting aspects of the specialty, especially attendance at out-patient clinics, and this may impact on recruitment and retention (potentially compounding the staffing situation).

The visit team welcomed the plans for a more coordinated approach to consultant working from November 2014, which should streamline consultant on-call and ward round arrangements and improve organisation and efficiency within the department, thereby enabling trainees to be released more frequently to attend clinics.

Recommendation

Explore the potential for other healthcare professionals to expand their roles within the department and provide a multi-professional solution to the medical staffing issues, which, in the long term, would be more sustainable. This may link in with the work of the Trust's New Roles Group.

4: Good practice and innovation

There are some areas of good practice already identified in Section 3 – 'Progress since last visit'. These emerged from the improvement work undertaken following that visit and include:

- ✓ The appointment of Education Leads within each CMG
- ✓ Development of a Quality Dashboard
- ✓ Implementation of the Education Strategy
- ✓ Establishment of the Medical Education Committee
- ✓ Work on the new library and provision of e-learning resources
- ✓ Sustained improvement of education and training within the Emergency Department and dissemination of this work regionally
- ✓ Further development of the system for identification of different training grades

The following are additional areas of good practice identified during the 2014 visit.

<u>Effective use of educational funding to support non-medical education and training</u>

This was the first year that HEEM has adopted a multi-professional approach to its quality management visits.

All non-medical student placements attract payment of a tariff to organisations providing the placements and holding a Learning Development Agreement (LDA) with HEEM. It is vital that this funding should be used to facilitate the provision of quality placements and meet regulatory standards (such as those of the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC)).

Over the last twelve months, UHL has been making effective use of the tariff funding to support the non-medical learning environment. Throughout the visit, the teams encountered evidence directly linking the use of the tariff funding to clinical quality and patient safety initiatives and to the quality of learning environments (see below).

Recommendation

The Trust should continue to support the HPCP tariff group in effectively utilising tariff funding to support patient safety and education and training initiatives.

<u>The learning environment for nurse students and learners within other allied healthcare professions</u>

Members of the team met with a range of learners on placements at UHL, including nursing students, students on the Operating Department Practitioners (ODP) diploma course, Physiotherapy students, Occupational Therapy students, Diatetics students and student Radiographers, as well as their mentors / supervisors and practice placement managers.

4: Good practice and innovation (cont'd)

The overall impression gained by the visit team was that all groups of learners were very happy with their placements and had no negative issues to raise. In particular, they felt:

- ✓ well supported and supervised at all times;
- ✓ able to raise concerns if necessary (and knew how to do this);
- ✓ that struggling students were well supported;
- ✓ that the relationships with the Higher Education Institutions were positive;
- ✓ that opportunities for inter-professional working and learning were strongly promoted across all the 'non-medical' workforce.

These views were shared by their mentors / supervisors and practice placement managers.

During the visit, one member of the team made an unannounced visit to a number of clinical areas at the LRI, including the Haematology department, Ward 29 and Acute Medical admissions areas. They talked with a range of staff within these areas. These conversations provided further, strong evidence of the Trust's support for non-medical training, including the support of learners on placements as well as their mentors / supervisors and the wider healthcare workforce (for example, through induction and preceptorships).

Trust leads for non-medical education and training also showcased a range of quality improvement and patient safety initiatives, including:

- ✓ the competent, caring, capable workforce project (developing a culture of compassion);
- ✓ the further development of inter-professional learning opportunities and multi-professional learning resources;
- ✓ clinical education to improve patient safety;
- ✓ supporting learning beyond registration.

Recommendation

Explore the extent to which the model for supporting the non-medical workforce could be transferrable to medical training.

<u>Respiratory Medicine</u>

The visit team met with trainee doctors and their trainers working in Respiratory Medicine at the Glenfield Hospital. While the feedback may have been skewed slightly by the fact the all of the trainees in the session were based on the Clinical Decisions Unit (CDU), the reports were of an excellent education and training environment, with consultants keen to teach. Of note was the fact that the workload is very high but that this is treated positively rather than regarded as a hindrance to learning – i.e. the many clinical events were, wherever possible, capitalised on by consultants as opportunities to teach their trainees.

4: Good practice and innovation (cont'd)

Cardiology

While there are a number of areas for improvement identified in Cardiology (see Section 5), the department was regarded as having excellent and unique clinical and academic opportunities and, with the expertise of the consultants, had the potential to be a centre of excellence. Also, the multi-disciplinary and electrophysiology meetings were singled out as excellent learning opportunities.

Gastroenterology

Induction and on-going support for junior trainees was reported as effective and comprehensive.

Histopathology

Trainees reported a high level of support from their consultants, with a good balance of supervision and autonomy.

Haematology

Trainees at all levels felt well supported, able to meet their curriculum requirements and would highly recommend the department as a place to train. The department has a track record of attracting trainees to Haematology at UHL and also of successfully providing examination support to trainees outside of the region. At the time of the visit, UHL had a 100% pass rate for the Fellowship Examination of the Royal College of Pathologists. The trainers should be commended for their work.

Dental training

In parallel to this visit, the new East Midlands Dental Dean and his team visited the Dental Department to review education and training arrangements. The visiting team met with Dental Core Trainees and separately with their trainers. The team encountered a department endeavouring to provide a positive training experience and no serious concerns were identified. Trainees reported some frustrations arising from not getting hands-on oral surgery experience for the first eight weeks of their placement, but that this was now beginning to happen. The trainers reflected that they had perhaps been overly cautious in their approach and would review this for next year. Comprehensive induction materials, provided to trainees, were shared with the visit team, and this was considered to be an example of good practice. Trainees felt that their placements at the LRI would provide them with good experience of managing a wide range of patients, especially now that they are being given their own minor oral surgery lists.

4: Good practice and innovation (cont'd)

Recommendation

Identify whether the models of teaching and training in place in Respiratory Medicine and Haematology can provide a template for other departments, particularly those which are struggling to maintain an appropriate training / service balance due to high service demands.

5. Areas of improvement

There are a number of areas for improvement identified in section 3. – 'Progress since last visit'. All recommendations and requirements are listed in section 6. This section identifies new areas for improvement identified from the 2014 visit.

Non-medical / medical education and training

While there was evidence of the development of inter-professional learning within non-medical professions, opportunities for doctors to learn with, and from, nursing staff and other allied healthcare professionals is (as in other areas of the East Midlands) in its infancy.

Also, the Trust's self-assessment highlighted inconsistency of practices across non-medical professions, particularly around feedback mechanisms for raising concerns.

Recommendation

Develop further inter-professional learning opportunities across both medical and non-medical groups.

Recommendation

Continue the work highlighted to HEEM to better standardise practices across non-medical healthcare professions, with the longer term aspiration to extend this to all healthcare groups (medical and non-medical).

General Internal Medicine on-call rota

Through feedback sessions with trainees and via conversations with staff in a range of clinical areas, the visit team became very concerned with overnight medical cover at the LRI. It was reported that three HST level doctors are required to provide cover to the medical wards at night but that, on a number of occasions, only one HST level doctor has been based at the LRI (for example if one is required at the LGH and the other has not been available). The trainees considered this to be a patient safety issue.

Requirement

A response from the Trust is required about the overnight medical cover at the LRI within three weeks of receipt of the final, agreed version of this report.

5. Areas of improvement (cont'd)

Cardiology

At HST level, Cardiology trainees described the department as offering fantastic and unique training and research opportunities and working alongside consultants with tremendous expertise. However, they felt unable to capitalise on the opportunities and expertise at present since their education and training was being compromised by high service demands and having to cover more than the recommended number of clinics per week (although they were already working with managers to resolve this). This poses a risk to trainees acquiring the required number of procedures to demonstrate competence and progress through their ARCPs. In particular, academic trainees felt that their academic time was not protected due to service demands. There also seemed to be a low threshold from those at the LRI seeking cardiac advice and for transferring patients, thereby exacerbating the workload problem. As a result of all of this, trainees reported that Cardiology at the Glenfield had a poor reputation for clinical training nationally (albeit a good reputation for academic opportunities) and that they would not recommend to colleagues and friends to train at UHL. Moreover, while the trainees at Foundation and Core level reported an excellent education and training experience and seemed unaffected by the service pressures experienced at HST level, they would not apply to Glenfield for specialty training as they had witnessed the problems experienced by their HST colleagues. This may have future workforce implications.

The provision of cardiac advice over the telephone was considered a patient safety issue, with trainees sometimes feeling uncomfortable about offering advice about patients they could not physically see and with no direct link to see ECGs.

It was reported that there is a lack of consultant presence on the CDU as the consultants are more often working in the Cardiac Catheterisation laboratory. While a HST level doctor will usually be present to assess patients before they are transferred to a ward, it is possible for patients to not receive a consultant review for a number of days (for example, if admitted to the CDU at the weekend and then transferred to ward where the consultant does not conduct a ward round until the middle of the week). The trainees suggested that this also poses a potential risk to patient safety.

Requirement

Work towards reducing the clinics burden on HSTs within an appropriate and realistic timeframe (to be agreed with HEEM). Both trainees and trainers felt that there may be non-medical workforce solutions to this.

Requirement

A response from the Trust regarding the issue of consultant presence on the CDU and provision of advice over the telephone, including an assessment of the risk to patient care, is required within three weeks of the receipt of the final, agreed version of this report.

5. Areas of improvement (cont'd)

Recommendation

Review the model of service delivery and staffing. This may result in small changes rather than large scale service reconfiguration. For example, it was suggested that a Cardiologist triaging directly within A&E might reduce the workload at the Glenfield Hospital and / or that Acute Medicine trainees (or from other specialties such as Geriatric Medicine) might benefit from time in Cardiology to increase their confidence to deal with straightforward cardiac cases when working at the LRI (as well as contributing to support the service at the Glenfield site). As already suggested, there may also be non-medical workforce solutions to reduce the workload for the Cardiology HSTs.

Gastroenterology

While, generally, trainees reported good education and training, the heavy workload, compounded by rota gaps (a national recruitment issue), is adversely impacting on their training, and would be impacting on patient safety also without the dedication of trainees working beyond their contracted hours on a regular basis. The current staffing levels appear to be unsustainable. While additional trainees and staff grade doctors might not be a feasible option, the department needs to link into the wider Trust work to look at new and existing clinical roles (as well as innovative Fellowship posts) and how these may be utilised to support services.

Histopathology

The trainees reported an on-going issue with facilities and a lack of resources and equipment.

The trainees would also welcome more constructive feedback from their trainers on a regular basis. It may be that service pressures on consultants has been a barrier to this.

Recommendation

While there are limitations to the physical space available at the LRI, if equipment is not fit-for-purpose and this is a barrier to training, then a business case for investment in equipment needs to developed by the department / Specialty School.

Medical Microbiology

Workload is high and the department is extremely busy but trainees feel that it is essential that education and training are prioritised.

While trainees do not routinely work alongside consultants and a model of peer-to-peer training appears to have been in place, there is now a move away from this; trainees have been organising a programme of local teaching with invited speakers and a consultant is now available for one hour per day to provide supervision and feedback.

5. Areas of improvement (cont'd)

In general, there has been an increase in on-the-job feedback provided by consultants. Trainees commented that the laboratory staff is always supportive and keen to teach.

The low level of direct, consultant supervision and opportunities for feedback may reflect the relatively low number of consultants within the department (with some working part-time and one having to dedicate time to a wider Trust role with apparently no back-fill).

Haematology

Although expected, and encouraged by trainers, to attend clinics, medical staffing levels make it difficult for Core Medical Trainees to leave the ward. This is further compounded by a large number of trainees working less-than-full-time in what appears to be an increasingly feminised medical workforce

Recommendation

Linking in with the wider Trust work to look at new clinical roles, the department should explore the potential for other healthcare professionals to support some of the activities traditionally undertaken by doctors only.

6. Recommendations and Requirements

Recommendations

1. Trust-wide: Consider how the new CMG Education Leads can engage, and work, with HEEM's Foundation and Specialty Schools and the Royal Colleges;

2. Anaesthetics: Review the current departmental teaching opportunities and develop a timetable of formal teaching sessions. This may include the establishment of monthly, half-day teaching (in coordination with surgical colleagues so that lists are timetabled to facilitate the sessions), potentially drawing on the 'divisional day' model already established for Anaesthetics in the North of the East Midlands;

3. Clinical Oncology: Explore the potential for other healthcare professionals to expand their roles within the department and provide a multi-professional solution to the medical staffing issues, which, in the long term, would be more sustainable. This may link in with the work of the Trust's New Roles Group;

4. Trust-wide: Explore the extent to which the model for supporting the non-medical workforce could be transferrable to medical training;

5. Trust-wide: Identify whether the excellent models of teaching and training in place in Respiratory Medicine and Haematology can provide a template for other departments, particularly those which are struggling to maintain an appropriate training / service balance due to high service demands;

6. Trust-wide: Develop further inter-professional learning opportunities across both medical and non-medical groups;

7. Trust-wide: Continue the work highlighted to HEEM to better standardise practices across non-medical healthcare professions, with the longer term aspiration to extend this to all healthcare groups (medical and non-medical).

8. Cardiology: Review the model of service delivery and staffing. This may result in small changes rather than large scale service reconfiguration. For example, it was suggested that a Cardiologist triaging directly within A&E might reduce the workload at the Glenfield Hospital and / or that Acute Medicine trainees and those from some other medical specialties (e.g. Geriatric Medicine) might benefit from time in Cardiology to increase their confidence to deal with straightforward cardiac cases when working at the LRI (as well as contributing to support the service at the Glenfield site). As already suggested, there may also be non-medical workforce solutions to reduce the workload for the Cardiology HSTs;

6. Recommendations and Requirements (cont'd)

9. Histopathology: While there are limitations to the physical space available at the LRI, if equipment is not fit-for-purpose and this is a barrier to training, then a business case for investment in equipment needs to developed by the department / Specialty School;

10. Haematology: Linking in with the wider Trust work to look at new clinical roles, the department should explore the potential for other healthcare professionals to support some of the activities traditionally undertaken by doctors only.

Requirements

1. Trust-wide: Ensure more regular trainee access to the Sim. Man. This is an issue extending to other specialties;

2. Anaesthetics: Ensure all rotas are at least 1 in 8. This is currently a Royal College requirement, although HEEM recognises that remains a challenge across the East Midlands;

3. Anaesthetics: The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed report, that it has processes in place to ensure that all new starters in Anaesthetics have access to the information they need to work effectively and safely in clinical areas before they commence work in these areas;

4. The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed report, that it has processes in place to ensure that all new starters have access to clinical systems on commencement at the Trust;

5. General Internal Medicine: A response from the Trust to the patient safety concern regarding medical cover at night at the LRI is required within three weeks of receipt of the final, agreed version of this report;

6. Cardiology: Work towards reducing the clinics burden on HSTs within an appropriate and realistic timeframe (to be agreed). Both trainees and trainers felt that there may be non-medical workforce solutions to this;

7. Cardiology: A response from the Trust regarding the issue of consultant presence on the CDU and provision of advice over the telephone, including an assessment of the risk to patient care, is required within three weeks of the receipt of the final, agreed version of this report.

7. Action plan

8. Providers response