

19th October 2015

We would like to thank the GMC for giving us the opportunity to respond to their report. The Trust team involved in the visit found the feedback very valuable and it has provided us with a renewed focus to work to resolve the issues raised.

We are pleased that major improvements were found in surgical education and training and that the juniors were complimentary about the support they received from the consultants, as well as the enthusiasm of the trainers. We were also pleased that the junior doctors, in the main, were appreciative of the support from the consultants and the education team. It was also pleasing to see that simulation training, the junior doctor patient safety group and the annual healthcare awards were recognised as areas that were working well. We were also pleased to note that the junior doctors did not report any bullying or undermining.

We have already satisfactorily addressed the one serious concern raised during the visit and are working to improve our performance in the other areas identified. The following plan gives a brief overview of the significant actions being planned and undertaken since the visit.

Yours sincerely



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Number	Paragraph in <i>Tomorrow's Doctors / The Trainee Doctor</i>	Requirements for the LEP
1	TTD 1.2	<p><i>Current terminology must be used when referring to the grades of doctors in training and designing rotas to ensure appropriate clinical supervision and expectations of doctors' competence.</i></p> <ol style="list-style-type: none"> 1. Communication has been sent to all divisions (divisional managers as well as support staff) to explain the correct terminologies to be used and the implications of using the wrong terminology. It has been emphasised that all rotas need to use the current terminology. 2. Communication has been sent to all trainees regarding the same. 3. Finally, communication to matrons and nurses has also been sent.
2	TTD 1.2	<p><i>Doctors in training must be appropriately supervised according to their experience and competence.</i></p> <p><u>Changes to ensure adequate cover for cold F1 at weekends, to address the concern raised regarding the 'gap' between 5 and 9pm at weekends.</u></p> <p>We have, as a trust been working towards increasing the cover for the wards at weekends and have actively invested and appointed non-training middle grade doctors to help with this.</p> <p>The rota has now been altered with the introduction of the additional middle grades, to provide 9am - 9pm cover for the wards at weekends. This ensures that both 'hot' and 'cold'</p>

		<p>teams have HST/middle grade cover.</p> <p><u>Changes undertaken and proposed to address the workload in medicine.</u></p> <p><u>Additional Non-training grade doctors</u></p> <p>To help ease the workload 9 additional non-training grades have been appointed</p> <p><u>Speciality ward based working</u></p> <p>The directorate has moved to a speciality ward based working model with junior doctors being ward based during their cold period. This helps to limit the patient numbers and ease the workload for them. Thus they are able to share the workload for the ward and bed base.</p> <p><u>Physician Associates</u></p> <p>We are also working closely with Canterbury Christchurch University to support the Physician Associate diploma programme due to start in January 2016. This will help us to train these professionals locally, and increase the chances of having them work in East Kent. This again will help improve the training and ease workload.</p> <p><u>Clinical Strategy</u></p> <p>Finally, the Trust is reviewing its clinical and education strategy and this looks at various options including training on one or two sites, in the medium to longer term.</p>
3	TTD 1.6	<p><i>Doctors in training must have well organised handover arrangements to ensure they understand their duties and how their post fits within the programme.</i></p> <p>Handover has been one of the areas targeted as part of the EDQUINs project and deals with both inter-hospital transfers as well as formal handover of patients within the hospital.</p> <p>The former has been strengthened through the</p>

		<p>CHOC (Clinical Handover of care group).</p> <p><u>Formal handover in Medicine</u>- Morning handover – has been commenced in CDU which is attended by all teams and a register is maintained. Morning board rounds are conducted on the wards as well. Handover at night and weekends have also been strengthened.</p> <p><u>Surgery handover</u> –Formal handover with registers takes place in surgery.</p> <p><u>Emergency Medicine</u> – Have implemented a new system (ABCDE handover tool) with three handover meetings during the day (at 8am, 3pm and evening). The 3pm handover meeting is mainly a board round.</p> <p>Careflow connect (an electronic tool which can be used for handover) is being rolled out across the Trust and will enhance handover.</p>
4	TTD 5.4	<p><i>Doctors in training must be free to attend organised educational sessions and other learning opportunities of educational value.</i></p> <p>Following the GMC visit and as part of the EDQUINs programme, there has been a complete review and revision of the educational programme for medicine, foundation and surgery trainees. A teaching dashboard has been established and innovative ways of learning have been instituted. These include webinars and simulation. The sessions are bleep free.</p> <p><u>Foundation</u>: A new FTPD has been appointed with support from an experienced TPD to revise the foundation teaching programme. These sessions have been designed to ensure consultant teaching with active feedback from the trainees. Trainee teaching representatives have been elected to actively feedback to improve quality.</p> <p><u>'Morning report'</u> – a unique teaching session which involves all trainees and during which an interesting or difficult case from the week before is discussed by the trainees, facilitated by consultant. Each case has some specific learning</p>

		<p>points for all doctors.</p> <p><u>Medicine</u>: Two core trainees undertook a QIP to improve the teaching programme and with the help of the Medicine Lead have drawn up a programme based on systems. Webinars and PACES teaching are being undertaken.</p> <p>HST training sessions are being planned as trust-wide events.</p> <p><u>Surgery</u>: Regular sessions on a Friday morning continue to be very popular.</p> <p><u>Emergency Medicine</u>: Friday morning teaching sessions which span all the clinical specialities and emergency presentations, remain very popular. This session is video-conferenced across the Trust.</p>
5	TTD 6.1	<p><i>Doctors in training starting a post or programme must be able to access timely trust and departmental inductions.</i></p> <p>The Trust induction has been reviewed and revised and a trust-wide induction group with representation from trainees has been set up. All F1 doctors have 10 days of induction which include shadowing. The trust is working towards getting the online learning modules and smartcards being made available to the doctors before they start, so that there is smooth transition. We are working towards this for August 2016.</p> <p>An induction package for trainees commencing out of sync has been developed.</p> <p>All departmental inductions have been streamlined and every doctor has a departmental and team induction. The medical education team has been working alongside the divisions to make this happen and has taken on the responsibility for keeping a register with the signatures of the trainees</p>

6	TTD 6.10	<p><i>Working patterns and intensity of work for foundation doctors in training must be appropriate for learning.</i></p> <p>In recognition of the heavy workload, additional investment has been made to recruit additional doctors at middle grade and core levels. This helps to support the foundation grade doctors and reduce the intensity of the work and hours. The model of working has also changed to ensure equitable workload. This has also addressed the issue of hours of work. The DME and Medical director hold regular meetings to get feedback from the trainees about their experience.</p> <p>Finally, the Trust is reviewing its clinical and education strategy looking at various options including training on one or two sites, in the medium to longer term.</p>
7	TTD 8.1	<p><i>The design and delivery of training for foundation doctors in training must be improved. The local education provider (LEP) must have the capacity to accommodate the practical experiences required by the foundation curriculum.</i></p> <p>A new FTPD has been appointed, along with an additional experienced physician and training programme director to review the entire Foundation programme and improve the quality of training of the doctors.</p> <p>This has resulted in a new format of the teaching programme, more emphasis on clinical scenario and low fidelity simulation teaching, webinars.</p> <p>Regular 1-1 meetings with the Foundation Programme director are being undertaken.</p> <p>Foundation representatives have been appointed for both the faculty group as well as for teaching.</p>

Number	Paragraph in <i>Tomorrow's Doctors/The Trainee Doctor</i>	Recommendations for the LEP
1	TD 6.32	<p><i>Incident reporting should be better used to facilitate learning.</i></p> <p>There is a regular 'Learning from incidents' session which incorporates learning from serious incidents that have occurred.</p> <p>There is also a newsletter 'Riskwise' which highlights the learning from various incidents.</p> <p>The junior doctor patient safety group review the incidents (anonymised) to disseminate the learning from it. An example of this is the 'better prescribing better care' initiative, emphasising the importance of accurate prescribing as many incidents involving junior doctors involved prescribing incidents.</p> <p>The datix system has been upgraded, so that the reporter gets an automatic acknowledgement of receipt of the report, so that the final report can be sent to the reporter as well.</p>
2	TTD 7.2	<p><i>Education is considered at board level but should be better incorporated. LEPs should have an executive or non-executive director at board level with explicit responsibility for education, and education should, where possible, be a standing item on the board agenda.</i></p> <p>We currently have an Executive Education Lead at Board level who is responsible for education. This is the director of HR. The Medical Director represents medical education at Board level. The Trust currently is scoping a new education structure integrating medical and other education and will review representation of medical education at Trust Board as part of this review.</p>

3	TTD 8.4	<p><i>There should be greater consistency in the allocation of SPA time for those with an educational role.</i></p> <p>A new job planning policy is being implemented which has had input from the DME regarding PAs for education. Workshops will be held to train appraisers to apply the policy and in particular the tariff for educational roles appropriately.</p>
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