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Pan-London Quality and Regulation Unit

Barking, Havering and Redbridge University Hospitals NHS Trust

Core Surgery, General Surgery, Vascular Surgery, Neurosurgery and Trauma and Orthopaedic Surgery

Specialty Focused Visit

Quality Visit Report

19 November 2015

Final Report

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Visit Details	
Trust	Barking, Havering and Redbridge University Hospitals NHS Trust
Date of visit	19 November 2015
Background to visit	The Care Quality Commission (CQC) inspected the Trust in October 2013, and found there were serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. The Trust was placed in special measures in December 2013. Since the inspection a new executive team had been put into place including a new chair, new members of the board, a chief executive, medical director, deputy chief executive, chief operating officer and a director of planning and governance. The executive team was being supported by an improvement director from the Trust Development Authority. A director of medical education had also just been appointed. The Trust developed an improvement plan ('unlocking our potential') that was being monitored and contributed to by all stakeholders on a monthly basis. The CQC re-inspected in March 2015 in order to check on improvements, apply ratings and to make a recommendation on the status of special measures. Overall, it was found that the Trust required improvement. Both Queen's Hospital and King George Hospital were rated as 'requires improvement'. Of the five key questions that the CQC asked, they rated the Trust as 'requires improvement' for caring, safe, effective and well-led; responsive was rated 'inadequate'. A Trust-wide Review had not been conducted by Health Education England since May 2013, and in the interim, there had only been one specialty-focused visit to geriatric medicine in April 2015. A Trust-wide Review was therefore arranged for November 2015 and various parallel specialty-focused sessions took place alongside the Trust-Wide Review over the course of this two day visit. The School of Surgery requested to align with this visit to conduct a review of various surgical sub-specialties which had not been inspected for several years.
Visit summary and outcomes	The visit took place on day two of the Trust-wide Review. The visit team met with a number of clinical directors and college tutors as well as trainees and trainers from core surgery, general surgery, vascular surgery, trauma and orthopaedic surgery and neurosurgery. No immediate mandatory requirements were issued for the surgical specialties. However, many of the trainees interviewed in the surgical sub-specialty sessions corroborated the views held by the trainees from the Trust-Wide Review, the medicine specialty-focused session and the foundation inspection (which had taken place on day one of the visit), particularly with regards to the 'plus one' patients (which had resulted in an immediate mandatory requirement being issued on day one). Furthermore, surgical trainees were also concerned that locum staff members were not given access to Trust electronic systems in a timely fashion, which resulted in log-ins being shared. This had been identified as an issue on day one by the otolaryngology trainees and had also resulted in an immediate mandatory requirement being issued to the Trust. See Trust-wide Review report for further details on these immediate mandatory requirements. During the final feedback session, the specialty lead congratulated the Trust on the improvements at Queen's Hospital since the last visit. The visit team found that there was a culture of training and education that was to be commended. The visit team heard positive feedback from the vascular surgical trainee particularly in relation to interventional radiology training. Similar positive feedback was also heard from the one core trainee interviewed (general surgery at King George Hospital). The visit team heard very positive feedback across the board for King George Hospital – the Trust seemed to be doing a great job with regards to colorectal training at this site. The neurosurgical trainees at Queen's Hospital appreciated the consultant presence at the new formal handover system which they found very useful. The visit team heard that trauma meetings were well attended by many consultants and were appreciated by all the trauma and orthopaedic surgery trainees. Trauma and orthopaedic surgery trainees also appreciated the amount of exposure they had to trauma.

	The visit team highlighted the following areas for improvement: At Queen's Hospital there were issues on the ward at night with inadequate numbers of nurses. Hospital at night had been introduced but the visit team felt that it required further development because the level that it was at in conjunction with the poor ward staffing at night could have a serious impact on junior doctors who were expected to cover inappropriate tasks. The visit team suggested that the Trust should consider introducing a consultant of the week system so that there were daily ward rounds carried out by a consultant. At Queen's Hospital there was an inadequate weekend handover of patients and the length of the weekend ward round was onerous which impacted on the trainees' exposure to the theatre list. The visit team recommended the introduction of a 12pm handover on Friday prior to the weekend on call so that all general surgical and vascular surgical patients could be handed over safely and appropriately. Alternative ways of structuring the vascular surgical firm could also be considered to optimise the training experience. The only issue at King George Hospital was the CEPOD (confidential enquiry into peri-operatives death) list on Friday; the visit team recommended that consultant anaesthetist presence should be introduced to this list. Not all general surgical trainees at Queen's Hospital were meeting the School of Surgery's requirements of attending a minimum of four half day lists and no more than two clinics per week. The trauma and orthopaedic surgical trainees were allocated to a consultant for six months but then on a weekly basis they covered other areas. Although the trainees themselves did not complain about this structure, the visit team was concerned about its ad hoc nature. Neurosurgical trainees at Queen's Hospital were also not attending four half day theatre lists per week. The visit team heard that discussions were taking place to try and improve theatre access for all trainees, particularly given the impending arrival of more junior trainees in early 2016. Parking permits were raised as an issue for trainees who had to travel quickly from Queen's Hospital to King George Hospital to meet their clinical and educational responsibilities. This also impacted negatively on patient care.

Visit team			
Specialty Lead	Professor Nigel Standfield, Head of London Specialty School of Surgery	**Trust Liaison Dean**	Dr Indranil Chakravorty, Trust Liaison Dean, Health Education England - North East London Office
Lead Provider Representative (vascular surgery)	Mr Keith Jones, Consultant Vascular Surgeon, St George's Healthcare NHS Trust	**Healthcare Professions Representative**	Louise Morton, Associate Dean for Healthcare Professions, Health Education England - North Central East London Office
Lead Provider Representative (core surgery)	Mr Abir Bhattacharyya, Training Programme Director, University College London Partners	**External Clinician (general surgery and core surgery)**	Mr Adrian Steger, Consultant General Surgery, Lewisham and Greenwich NHS Trust
External Clinician (trauma and orthopaedic	Mr Suhaib Sait, Consultant Orthopaedic Surgeon, Dartford and Gravesham NHS Trust	**Trainee Representative (neurosurgery)**	Dr Samir Matloob, University College London Partners trainee representative

surgery)			
Lay Representative	Jane Gregory, Lay Member	**Visit Officer**	Jane MacPherson, Deputy Quality and Visits Manager

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement / Recommendation
GMC Theme 1) Learning environment and culture			
S1.1	**Patient safety** Many trainees interviewed highlighted the shortage of nurses on the ward, particularly at night, but commented that this was a national problem and was not exclusive to Barking, Havering and Redbridge University Hospitals NHS Trust. The general surgical higher trainees commented that they had no concerns about patient care at the Trust despite the shortage of nurses. The visit team heard that at times the trainees felt under pressure to discharge patients and there were often delays in moving patients from the emergency department to the wards. The trainees commented however that the same problem persisted at many Trusts and they did not think that patients suffered as a result of delayed discharge; they added that many patients came back to the hot clinics. The visit team heard that no consultant of the week system was in place at Queen's Hospital. The trainees agreed, however, that hospital at night required some development. The trainees stated that the core trainees were expected to carry out relatively menial work at night at Queen's Hospital (which was previously undertaken by foundation trainees) which meant that the higher trainees had to clerk patients. The visit team heard that the quality of the emergency department at Queen's Hospital was sub-optimal. Some trauma and orthopaedic surgery (T&O) higher trainees commented that they received inappropriate referrals although they pointed out that this was not a patient safety issue. Some core trainees, who had attended trauma calls, felt that some of the emergency department middle grades did not always follow advanced trauma life support (ATLS) guidelines, but as core trainees they had felt unable to raise this issue. Lack of bed capacity was raised as an issue particularly in neurosurgery. Lists had had to be cancelled as a result of insufficient beds. In T&O, the department had access to admitting beds, so this helped alleviate the bed capacity issues.	The visit team recommends that the Trust considers introducing a consultant of the week system so that there are daily ward rounds carried out by a consultant. Review how trauma calls are conducted to ensure that they are run according to ATLS guidelines.	Recommendation Mandatory Requirement

S1.2	**Serious incidents and professional duty of candour** The general surgery divisional director reported that trainees were encouraged to report incidents but he admitted that under-reporting was an issue. He stated that there was a commitment to give feedback to trainees on any incident reported. The trainees interviewed seemed happy to report incidents although many had not since they had assumed that other members of the team had reported the incident. None was aware of the weekly patient safety summit highlighted by the medical director to the visit team on day one of the visit. The visit team heard an example of a higher trainee who had asked a core trainee to report an incident regarding a breach of information governance (the core trainee had emailed patient information via an insecure email provider). The higher trainee was keen to receive remote access to Trust systems at home to avoid further breaches of this nature.	See Trust-wide Review report. The Trust should provide systems that facilitate off-site clinical support of trainees' work while meeting information governance requirements.	Mandatory Requirement
S1.3	**Appropriate level of clinical supervision** **General surgery** The visit team heard that good clinical supervision provision was in place. A nominated person issued a rota for a period of six weeks which indicated who the foundation trainees needed to contact if they required assistance. The service lead reported that if there were gaps in the rota, plans were put in place to fill these and that in practice everyone should be supervised. The visit team heard from educational and service leads that every patient was seen by a higher trainee (or equivalent non-training grade) every day. When occasions had arisen where trainees felt they needed more supervision, this had been raised as an issue with the local faculty group and had been dealt with locally. The general surgery educational leads commented that the volume of work was growing but that resources had been increased to deal with this, although they admitted that this was still a work in progress for the weekend. The divisional director stated that although some trainees struggled with the heavy workload when they first arrived at the Trust, good consultant support was in place and therefore the trainees adapted to the challenge quickly. **Neurosurgery** The visit team heard that the junior trainees received a high volume of referrals which they found difficult. The department had decided to purchase referral patient software which the department hoped would help ease the trainees' workload. A hot clinic had also been introduced which was run by Trust doctors and this had also proved helpful.		
S1.4	**Rotas** **General surgery**		

	At Queen's Hospital, the trainees were on a one in 12 rota with three higher trainees on call every day, one on daytime emergency department cover, one on nights and one on the CEPOD (confidential enquiry into peri-operative deaths) list. This seemed an excessive number of people but the trainees assured the visit team that this worked really well, not only for service but particularly for training. Patients were seen by the emergency department first although the amount of filtering was reported to be minimal. The visit team heard that there was a hot clinic filled with referrals from the surgery team and from the general practice team. This functioned as a surgical assessment unit. Some of the walk-in surgical referrals also used this service. The trainee covering the emergency department received a large number of phone calls during the 12 hour period. The visit team heard that approximately 12 patients were admitted during the day and six at night. The trainees at Queen's Hospital reported that there was always someone that they could call for assistance when on call. Since there were two emergency consultants on duty in addition to the on call consultant, this meant that there were three potential consultants to contact; the trainees commented that this was much better than in other hospitals where there might only be one consultant available. Trainees on call finished nights on a Monday morning and then returned to work on the Tuesday morning. The trainees at Queen's Hospital commented that they had to undertake a weekend ward round of at least 90 patients on a Saturday and a Sunday; they found this particularly gruelling, especially when they were unable to attend the CEPOD list which they would find educationally more valuable for their training. They felt that this protracted ward round impacted quite heavily on their overall training time. The visit team received a letter from a trainee who had recently completed a core surgical training year two post in general surgery at Queen's Hospital. The trainee reported that the workload was heavy but enjoyable. The trainee also stated that core trainees appreciated that they were not expected to take referrals. The core surgical training year two (CT2) trainee in the general surgery post at King George Hospital was extremely complimentary about her entire experience and stated that it was 'the best year so far in postgraduate training'. Having come from a busy hospital, she found the workload at King George Hospital more than manageable. The higher general surgery trainees at King George Hospital reported that they were on a one in eight rota with four numbered trainees and four Trust grade doctors. They undertook blocks of three or four days on call. They commented that they were very busy and operated every night. The trainees reported that the on-call rota worked well and that when on call during the day, there was a core trainee clerking patients in the emergency department, which meant that the higher trainee could concentrate on elective work. One trainee reported that King George Hospital was	Consider introducing a 12pm handover on Friday prior to the weekend on call so that all general surgical and vascular surgical patients can be handed over safely and appropriately. Consider other staff being involved in looking after existing inpatients at the weekend to reduce the burden on the on-call team.	Mandatory Requirement

	'the most functional hospital' that she had worked at in years. Trainees reported that the balance between service and training was very good. The visit team heard that one higher trainee (or Trust grade doctor) was allocated to the CEPOD list during the day, and that this list took place every afternoon. Each trainee was allocated to the CEPOD list for one half day per week. The educational supervisors reported that they did not have any consultant anaesthetist support at the Friday afternoon CEPOD list at King George Hospital, despite requests for assistance. This inevitably resulted in delays and missed training opportunities for the trainees. The higher general surgery trainees from both sites commended their training and education experience and the senior support they received. The less senior trainees commented that they would appreciate additional intermediate operative opportunities for them to gain confidence in independent operating. The visit team heard that the emergency department at both sites was very busy. The heavy workload was exacerbated by the high number of targets and by insufficient numbers of emergency medicine higher trainees.	The visit team recommends that consultant anaesthetist presence should be introduced to this list.	Recommendation
	Vascular surgery The visit team heard that there were six consultants in the department with two numbered higher trainees and three non-training registrar-grade trainees (although one was due to go on maternity leave bringing the total number at this level to four). There were also two core trainees and five foundation trainees. The firm was divided into two groups of three consultants. Each team had one consultant who covered vascular surgery with vascular on calls and two consultants who covered vascular with general surgery on calls. The vascular trainee interviewed was on call for everything, not just vascular cases. The trainee was happy with this structure. The visit team heard that the current structure was not particularly favourable to the foundation trainees on one site as they did not feel sufficiently supported. Therefore the higher vascular trainees were in the process of changing the rota, possibly to a system whereby there would be one big firm rather than two separate firms. The educational supervisors commented that when this was raised as an issue they reacted quickly by proactively organising a meeting to discuss the issues raised. The educational supervisors were supportive of moving to a one firm system.	The visit team recommends that the Trust considers alternative ways of structuring the vascular surgical firm to optimise the training experience. Consider establishing a firm of three with shared junior trainees or a whole merged firm (six consultants) with a consultant of the week system.	Recommendation
	The vascular surgery trainee interviewed reported that his training opportunities were not diluted by the presence of a number of clinical fellows in the department; he commented that they were supportive of his training needs. The vascular trainee echoed the higher general surgery trainees' concerns about the weekend ward round (mentioned above). He reported that he had suggested introducing a Friday afternoon handover, which had met with a varied response, mainly because it conflicted with the CEPOD list.	See above.	
	T&O	The Trust should review the T&O trainees'	

	The T&O higher trainees reported that they were given a 16 week rota which indicated in broad terms when they would be on call with their consultant. In addition to this, a weekly rota was sent out on a weekly basis. The trainees reported that they had a three week rolling rota with their consultant but also had the opportunity to cover other areas for one or two sessions each week. The trainees themselves appreciated this variety and felt well supervised. The visit team heard that trainees undertook a week long trauma week with their consultant. During that week they had exposure to a great deal of trauma whereas at other times they had limited exposure. The trainees confirmed that they were attending at least four half day theatre lists per week and no more than three clinics (including one specialist clinic). The core surgical trainee in the T&O post reported that he was on a one in ten rolling rota and had plenty of opportunity to attend theatre lists and clinics. He had already carried out more than 40 cases in six weeks. He commented that this job was known to be the 'best in London'. The visit team heard that the other nine people on the rota were Trust-grade doctors, many of whom were locums. The higher trainees reported that they were resident on call for 12 hours and on average admitted 12 to 15 patients per night. They felt that their presence was required overnight and that core trainees would find the workload too onerous. Furthermore, they indicated that the sub-optimal quality of locums made it difficult to manage ward patients appropriately as often the locums were unfamiliar with the handover system. They added that many locums were not given an induction when they started or appropriate access to Trust electronic systems. The trainees felt that unless there was a reliable layer of doctors at core-level, it would be very difficult for the higher trainees to be removed from the resident on call rota.	indicative curriculum numbers to ensure that they are achieving the appropriate numbers for their sub-specialty. See Trust-wide Review report.	Recommendation
S1.5	**Induction** All the trainees interviewed had attended a Trust and departmental induction apart from one neurosurgery trainee who had been unable to complete an induction due to clinical commitments.		
S1.6	**Handover** **General surgery** The visit team heard that there was a very thorough handover system in place in general surgery. Two higher trainees from the day and night and two core trainees from the day and night met on the ward or in the doctors' mess. The visit team heard that consultants conducted a morning post-take ward round. Others conducted a ward round every 12 hours. **Vascular surgery** The visit team heard that there was a morning ward round of the vascular surgery patients.		

	T&O The trauma meeting acted as a handover meeting at 8am. There was also a handover meeting at 8pm when a board round was completed, often by the higher trainees, since many of the short-term locums were ill-equipped to complete this task. **Neurosurgery** The neurosurgery trainees applauded their new morning handover meeting, which was attended by two to three consultants; cases were discussed and the trainees felt that the meeting was of huge educational value.		
S1.7	**Protected time for learning and organised educational sessions** **General surgery** The core trainee in general surgery at King George Hospital reported that she was released to attend mandatory training. The core trainee in general surgery at Queen's Hospital also confirmed that she had attended weekly teaching which she had found useful and interesting. The higher general surgery trainees stated that they were not all able to attend every lecture-based teaching session due to their clinical commitments. They saw no reason why the Trust grade doctors could not cover their workload so that they could all attend, but they felt that someone would need to coordinate this. **T&O** The higher T&O trainees reported no issues in being released to attend training. They also commented that they could complete academic work if they wanted to but this was not timetabled. The core surgical trainee in the T&O post reported that he could attend anatomy training if he wanted to but instead chose to use his annual leave to complete his anatomy training in one block. The higher specialty training year three trainee reported that he was released to attend the weekly teaching at the Royal National Orthopaedic Hospital NHS Trust. **Neurosurgery** The trainees reported that they would appreciate a fortnightly dedicated teaching session. They were, however, able to attend their monthly regional teaching. The educational supervisors commented that that they were trying to improve the trainees' educational experience by setting up journal clubs and audit sessions.	The Trust should ensure that opportunities for trainees to attend teaching sessions are optimised, for example, by using Trust grade doctors to cover the trainees' workload at these times. The neurosurgical trainees' timetable needs to be organised and formalised so that trainees are timetabled to attend educational sessions such as theatre lists and clinics. Consider pairing up a senior trainee with a junior trainee.	Recommendation Mandatory Requirement
GMC Theme 2) Educational governance and leadership			

<table>
<tr><td>S2.1</td><td>Effective, transparent and clearly understood educational governance systems and processes

The educational leads felt that the quality and patient safety agenda had improved since the last visit. They agreed however that trainees were not yet very engaged in governance meetings because of their workload.</td><td></td><td></td></tr>
<tr><td>S2.2</td><td>Appropriate system for raising concerns about education and training within the organisation

The visit team heard that the surgical tutors attended the education team meetings and that local faculty groups were now robustly in place. Issues were raised via the local faculty group meetings and escalated, as required, to the education team meetings, which in turn fed into the Board.

General surgery

The visit team heard that trainees were contacted prior to their arrival at the Trust to discuss their educational needs. The educational lead reported that he gained a good understanding of any training issues at the local faculty group meetings. During these meetings, the consultants tried hard to understand the General Medical Council National Training Survey results and address any issues.

Despite the reduction in numbered core surgical trainees across London, the visit team heard that the Trust had increased the number of core-level posts to try and support the overall training environment.

T&O

The educational supervisors reported that the department had changed significantly since the last visit. Many new consultants had been recruited. Although shocked by the findings at the last visit, the department had taken the criticism on board, addressed many training issues and as a result was now in a much better state and trainees were much happier.

Neurosurgery

The visit team heard that the department had only higher trainees at the time of the visit but that from February 2016 junior trainees would be allocated to the Trust. Educational supervisors were keen to understand how they could influence the allocation of trainees to the Trust in future.</td><td>The visit team recommends that discussions take place with the training programme director for the region so that the department can request the correct allocation of trainees.</td><td>Recommendation</td></tr>
<tr><td colspan="4">GMC Theme 3) Supporting learners</td></tr>
<tr><td>S3.1</td><td>Access to resources to support learners’ health and wellbeing, and to educational and pastoral support

Parking permits were raised as an issue for trainees who had to travel quickly between Queen’s Hospital and King George Hospital to meet their clinical and educational responsibilities. The trainees also felt that this also impacted negatively on patient care as they were often unable to</td><td>The visit team recommends that the Trust establishes a system whereby parking passes are passed from trainee group to the next trainee group, so that the lengthy delays and</td><td>Recommendation</td></tr>
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	arrive at their next clinical commitment on time. The trainees felt that the Trust had not been as proactive as it might about trying to resolve this issue.	subsequent negative impact on patient care and training opportunities are eliminated.	
S3.2	**Behaviour that undermines professional confidence, performance or self-esteem** No issues were reported in this area. The trainees commented that if they witnessed or were the subject of inappropriate behaviour, they would be more than happy to speak to their consultants or their educational supervisor or head of department.		
S3.3	**Access to study leave** No major problems were reported in this area. Some trainees commented that at times they had to wait for a considerable time before approval for study leave or annual leave was granted.		
GMC Theme 4) Supporting educators			
S4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The educational supervisors reported that this had improved since the last visit and that they were now given appropriate programmed activity to meet their educational requirements. Some educational supervisors expressed their frustration at the lack of core surgical trainees at the Trust particularly when there were so many training opportunities available. The surgical tutor reported that the vast majority of trainers had completed the required competency training and that those who had not had been notified of the need to do so. The trainers reported that they were supported if they wanted to be released to attend other commitments such as recruitment or matching interviews.	The visit team recommends that the Trust should organise a Careers Day to try and attract core trainees to the Trust.	Recommendation
GMC Theme 5) Developing and implementing curricula and assessments			
S5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team heard that the Trust had recently set up a divisional structure but a divisional lead had yet to be identified in many cases. The new director of medical education (a urologist at King George Hospital) was expected to be involved in establishing how the divisional structures would prioritise education. **General surgery** The visit team heard that there was a well-established training programme set up at both sites in general surgery and that many of their core surgical trainees had successfully been recruited to higher specialty training. The educational leads commented that many higher trainees chose to		

	return to the Trust after spending a year here. The educational leads reported that the core and higher trainees always had good feedback for the department. The educational supervisors commented that there was an excellent provision of breast service which would hopefully be expanded. They felt that this service offered immense opportunities for both core and higher trainees. **Vascular surgery** The vascular surgery department suggested that there was capacity for additional vascular surgery trainees now that the department was fully staffed. The vascular surgery trainee felt that two trainees were sufficient for the department. **T&O** The educational leads reported that trauma exposure was excellent for the trainees and that there were many training opportunities. The previous surgical tutor reported that when trainees had previously complained that they were not attending enough operating lists, he had changed the rota so that they were able to attend. He felt that this demonstrated the department's keenness to train. Overall, the educational leads felt that the department was strong and supportive. **Neurosurgery** The visit team heard that the neurosurgery department had been hampered by vacancies. The department had found it difficult to recruit at short notice and this had impacted negatively on the trainees' experience. Nevertheless, the educational leads felt that the quality of training had progressively improved. The visit team heard that there were no theatre lists or clinics without a consultant presence. Educational supervisors reported that there was a total of 80 hours of scheduled operating which trainees could attend.		
S5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** **General surgery** The visit team heard that the higher trainees at Queen's Hospital were not routinely attending the required four half day theatre lists per week and at times were attending more than two clinics. The higher trainees at King George Hospital, on the other hand, reported no issues in this area. The core surgical trainee who had recently completed a year in the general surgery post at Queen's Hospital stated that she had completed 357 cases in 12 months. The core surgical trainee in general surgery at King George Hospital reported that she was able to gain exposure to exactly what she needed for her stage of training. She commented that trainers were keen to teach, the rota incorporated clinics, on call and theatres and she attended more than the required four half day lists per week. She felt that the post was very much geared up for	Review and revise the Queen's Hospital higher general surgery trainees' timetables to ensure that they are attending a minimum of four half day theatre lists and no more than two clinics per week.	Mandatory Requirement

	training and education rather than service. She also reported that there was no conflict with the Trust fellows. **Vascular surgery** The vascular surgery trainee reported that his exposure to interventional radiology was excellent and the best part of his job. Relationships with the interventional radiology team were reportedly very good; since they had no trainees, they were keen to teach the vascular surgery trainee. He reported that they 'bent over backwards' to teach. Although the vascular surgery trainee was covering the general surgery on calls, despite the curriculum saying that this was not required, the trainee did not think that this was deleterious to his training. **T&O** The higher trainees reported that although busy they were enjoying their post. They felt very well supervised and commented that they could not fault their experience at the Trust. They stated that Queen's Hospital was well known as the best place to increase trainees' logbook numbers. There were one and a half trauma lists every day and on alternate days there were two lists; on Sundays there were three. The trainees reported that the rota coordinators were good at prioritising their training needs. For example, on one occasion the rota coordinators had moved one trainee from a clinic to a theatre list and instead had allocated a Trust grade doctor to the clinic. This was considered very good practice by the visit team. The trainees reported that trainers were keen to teach, particularly at the trauma meeting. The trauma meeting was reported to be well attended, often by seven or eight consultants. Very useful discussions took place at these meetings.		
	Neurosurgery The neurosurgery trainees reported that the on call was more intense compared to other units but they found their consultants to be approachable and friendly. The visit team heard that the trainees were not attending the required four half day operating lists per week. Meetings had taken place within the department to try and address this, particularly considering junior trainees would be allocated to the Trust from February 2016. The visit team heard that the senior trainees were keen to ensure that the junior trainees would be able to attend theatre lists, but they commented that the junior trainees would need to be proactive. The visit team heard that there were eight middle grade doctors in post and that there was no distinction between training grades and non-training grades. Trainees were not prioritised to attend theatre lists. This had also been discussed in local faculty group meetings. The trainees themselves did not think that the Trust grade doctors detracted from their training experience but they instead commented that they could enhance their learning since they were more experienced and could supervise them. The higher trainees reported that they were working with consultants to try and establish a rota	The visit team recommends that the neurosurgery department establishes a formal system whereby each higher trainee works for two consultants, and whereby a senior trainee is paired with a junior trainee. The neurosurgical trainees' overall experience would also be improved by a dedicated local teaching programme.	Recommendation

	whereby a senior trainee worked with a junior trainee. They commented that there was a willingness to improve the rota.			
S5.3	**An educational induction to make sure learners understand their curriculum and how their post or clinical placement fits within the programme** Some trainees had not yet held an initial meeting with their educational supervisor nor did they have learning agreements in place despite the fact that they had started in post some time ago.	Ensure that all trainees are able to meet with their educational supervisor and sign a learning agreement within the first month of starting in post.		Mandatory Requirement
	Appropriate balance between providing services and accessing educational and training opportunities Trainees across the board praised King George Hospital as an excellent site; retention of staff was reported to be good.			
Good Practice		**Contact**	**Brief for Sharing**	**Date**

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Professor Nigel Standfield*
Date:	*22 December 2015*