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Quality and Regulation Team (London and South East)

Royal National Orthopaedic Hospital NHS Trust
Trust Wide Review

Quality Visit Report

15 December 2015

Final Report

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Visit Details	
Trust	Royal National Orthopaedic Hospital NHS Trust
Date of visit	15 December 2015
Background to visit	The Royal National Orthopaedic Hospital NHS Trust (RNOH) is the largest orthopaedic hospital in the UK. The Trust was last visited in October 2012, for an Annual Quality Visit (AQV). At the 2012 AQV, the visit team highlighted five areas that required improvement. The GMC National Trainee Survey 2015 generated one red outlier in 'adequate experience' in trauma and orthopaedic surgery. Anaesthetics generated three pink outliers in 'clinical supervision out of hours', 'induction' and 'feedback' along with three green outliers in 'handover', 'workload' and 'local teaching'. The Care Quality Commission (CQC) visited the Trust on 15 August 2014; the CQC found that the Trust was in need of improvement. The key findings from the CQC were that: the building was not suitable for all service users, the World Health Organisation (WHO) surgical safety checklist was not always being used, staff did not have an appropriate level of safeguarding training, and, lastly, the learning from incidents needed to be shared across the Trust. At the time of the visit the Trust informed the visit team that the director of medical education (DME) had resigned and a new DME was due to be appointed shortly.
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit and the well-attended sessions the visit team encountered. The visit team met with the chief executive officer, medical director, human resources director, medical education manager, medical resourcing manager, associate medical director and library manager. The visit team then met with one year two core surgical trainee, eight higher surgery trainees ranging from specialty training grades three to eight (ST3-8), eight educational and clinical supervisors, five higher anaesthetics trainees ranging from specialty training grade five to seven (ST5-7), one higher paediatric trainee, one post-certificate of completion of training (CCT) histopathology trainee, one higher rehabilitation medicine trainee, five educational and clinical supervisors, one paediatric educational supervisor and one rheumatology educational supervisor. The visit team noted one area of serious concern and an immediate mandatory requirement (IMR) was issued. The visit team heard that the Trust had investigated a never event incident involving a trainee and had provided adequate support. However, the responsible officer (postgraduate dean) was not informed about the trainee involvement, which was a statutory requirement. The visit team noted the areas that were working well. The Trust was to be commended on the high quality and experience the anaesthetics trainees received. All the specialty trainees reported they were well supported. The anaesthetic department was commended for the half-day bleep-free teaching the trainees received. This was praised for its content and the effort that went into ensuring that it occurred. The anaesthetic department was aware of the risks in covering paediatrics post-surgical patients out of hours and had ensured trainees were appropriately trained and well supported. This included an appropriate paediatric specific induction programme and the provision of advanced life support training for all anaesthetic trainees on this rota. The surgery department was to be commended on the high quality learning environment that it provided to trainees. However, the visit team noted the following areas for improvement. • The simulation centre needed to be utilised for not only specialty-specific training opportunities but trust-wide team based and multi-professional training. • The Trust was required to have an auditable and well-documented formal handover system for all clinical areas across the Trust that could also be used as a learning opportunity for trainees.

	• The Trust was required to ensure there were formally appointed trainee representatives for all specialties to represent the department at the Trust local faculty group with formal minutes presented to the education department • The Trust was required to review and work with the paediatric department to utilise all educational opportunities available for trainees including outpatient clinics in paediatric and allied medical specialties as well as multi-disciplinary team meetings (MDTs). The visit team recommended that this work should be undertaken alongside the Trust Liaison Dean and Head of School for Paediatrics. • The anaesthetic department was required to review, with the training programme committee, whether the three month rotation, which some trainees experienced, could be extended to six months to ensure that all trainees were able to make the most of their time at the Trust. • The Trust was required to review the training experience and opportunity of core surgical trainees within the Trust to ensure curriculum requirements and exposure to emergency trauma surgery were also met. The visit team recommended that a programme should be developed to show how the Trust would ensure training needs were met by the end of January 2016.

Visit team

Lead Visitor	Dr Indranil Chakravorty, Trust Liaison Dean, Health Education England North Central and East London	**Surgery Specialty Lead**	Professor Nigel Standfield, Head of London Speciality School of Surgery
Trust Liaison Dean	Dr Andrew Deaner, Trust Liaison Dean, Health Education England North Central and East London	**Deputy Surgery Specialty Lead**	John Brecknell, Deputy Head of London Speciality School of Surgery
Anaesthetics Specialty Lead	Dr Cleave Gass, Head of London Specialty School for Anaesthesia	**Lead Provider Representative**	Professor Fares Haddad, Associate Director for the Surgical Specialties Board, UCLPartners
Local Education Training Board Representative	Alain Haines, Delivery and Support Administrator (Medical and Dental), Health Education England North Central and East London	**Lay Member**	Kate Rivett, Lay Representative
Visit Officer	Victoria Farrimond, Quality and Visits Officer		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			
1.1	**Serious incidents and professional duty of candour** The visit team heard from the Senior Management Team (SMT) that the Trust had supported a trainee following a never-event. The support provided involved discussions around the never-	The visit team heard that the Trust had investigated an incident involving a trainee and	Immediate Mandatory

	event and pastoral support for the trainee. The SMT reported that following the never-event the World Health Organisation (WHO) checklist was updated and further work was undertaken regarding how to prevent never-events. The visit team was concerned that this incident had not been reported to Health Education England which was a statutory requirement. The visit team was told that the medical director had access to all the serious incidents within the Trust and depending on the level of incident then dealt with the serious incidents locally on a Trust level. A formal system of review with the Director of Medical Education (DME) and information being updated electronically on six monthly returns was not established. The SMT stated that they had set up a junior doctor weekly programme of teaching in trauma and orthopaedic surgery from April 2015. At the beginning of the teaching there was a doctors' forum in which serious incidents, learning points and guidelines were discussed. The SMT indicated that with the recruitment of a new director of medical education the issues regarding the reporting of serious incidents would be resolved and the Trust would continue to work on this to ensure all the relevant regulatory bodies were made aware of serious incidents. The visit team heard that the clinical governance lead was on the sub-board. The clinical governance lead usually discussed serious incidents at a multi-professional committee and followed the incidents through to the conclusion and presented this information to the Trust's quality committee. The SMT commented that they were aware of under-reporting and encouraged all staff to report incidents as appropriate. The process for reporting incidents was based on an electronic form. The Trust was going to work on further encouragement of staff to report and promote an open and blame-free culture. The visit team heard that all trainees were made aware of the process to report serious incidents and to inform the appropriate line manager following a serious incident. However, very few trainees had actually reported incidents so could not inform the visit team if a formal system of receiving feedback was available. The higher surgery trainees appeared to be unaware of learning points and educational aspects of serious incidents being formally shared or disseminated with the trainees. The trainees informed the visit team that there was a table on the homepage of the website with common patient safety issues. The visit team was told by the educational supervisors that the Trust hosted regular audit meetings that all staff were invited to attend.	had provided adequate support. However, the responsible officer was not informed about the trainee involvement, which was a statutory requirement. The Trust is required to develop a formal system of regular reviews of all serious incidents where a trainee is involved. The DME should be involved in the process and ensure that it meets with current HEE guidelines for reporting. All such incidents should be reported formally via electronic return to HEE. A copy of this policy should be sent to the Quality and Regulation Team (London and South East). The Trust is required to demonstrate that the learning points from investigation and analysis of incidents is formally fed back to trainees on a regular basis and when appropriate is used in simulated, multi-professional learning events. The Trust clinical governance lead should be responsible for this and opportunities for trainees to participate in quality improvement activity related to this should be explored.	Requirement Mandatory Requirement Mandatory Requirement
1.2	**Responsibilities for patient care appropriate for stage of education and training** The visit team heard that if a patient became medically unwell the trainees would contact the anaesthetist on call or consultant on the intensive therapy unit (ITU). The trainees reported that support for medically unwell patients was very responsive. The visit team heard that it was possible to get a visiting medical consultant (liaison physicians) to		

	review patients on a semi-urgent basis and a cardiologist visited the Trust from Barnet Hospital three times a week. The anaesthetic trainees reported that when there were medically unwell patients the liaison physicians were accessible. The ITU team were helpful in assisting with unwell patients and liaising with transfers off site, if required. The visit team heard that the anaesthetic trainees were asked if they had the relevant European Paediatric Life Support and Advanced Life Support competencies on arrival at the Trust and if trainees had not, a course would be arranged. The visit team heard that the paediatric consultants were supportive in providing appropriate training for managing paediatric patients. The visit team heard that the paediatric trainees undertook a lot of routine phlebotomy and trainees were often called out of clinics to take blood samples. This was felt to not be a suitable task for a higher paediatric trainee.	The Trust is required to review the formal provision of a phlebotomist on the paediatric ward.	Mandatory Requirement
1.3	**Rotas** **Surgery** The visit team heard that trainees arrived at 7am and did not leave till 6pm most days, and 8pm on theatre days. The higher surgery trainees reported that there were 23 higher trainees and with five middle-grade Trust doctors this made a rota of 28 providing on call cover for the whole hospital. The visit team heard that higher trainees undertook one weekend on call and five weekdays on call in each six month placement. The rota was managed by a senior surgical trainee. **Anaesthetics** The visit team heard that the anaesthetics trainees carried out one month in intensive care, one month in theatre which alternately rotated during their placement at Royal National Orthopaedic Hospital NHS Trust (RNOH). The trainees were on a one in eight rota. The anaesthetic trainees reported that there was a high turnover of level two patients, which kept the trainees busy throughout the day. The visit team was told that if patients were required to go back into theatre the consultant would attend to the patient and the trainees would cover the ITU. The anaesthetics trainees covered paediatrics overnight. All trainees had received a paediatric induction which was led by the paediatric consultants. The anaesthetic educational supervisors reported that the rota changed in 2013 to change the hours to long days and nights for on call cover. **Trust Wide Review** The paediatric trainees stated that they worked days and weekends at the Trust and attended on call shifts at Northwick Park Hospital. The paediatric educational supervisors reported that there was 365 day, 24 hour cover on the paediatric ward.	The Trust is required to undertake six monthly review of European Working Time Directive compliance of all rotas via two week diaries as per HR guidance.	Mandatory Requirement

1.4	**Induction** The medical education manager (MEM) informed the visit team that induction was well managed. The Trust was fully aware of when trainees rotated which enabled plans to be made in advance of trainees commencing at the Trust. The Trust had a list of educational and clinical supervisors to inform the trainees when they started. The educational supervisors (ES) and clinical supervisors (CS) in surgery informed the visit team that they were often informed rather late of trainee allocations so were unable to arrange to clarify individual trainees' requirements before they arrived. This information would be useful to tailor team/firm allocations based on specific training needs. The postgraduate medical education department kept a record of the teaching provided and attendance sheets; this information was entered into the Electronic Service Record. Copies of trainee attendance and involvement for teaching and induction were available in print-outs for the trainees to take with them for interviews or next rotations. The anaesthetic trainees informed the visit team that they had a day of Trust and departmental inductions, which the anaesthetic trainees found useful.	The Surgical Tutor is required to work with UCL Partners Training Programme Management Committee Chair in formalising the process and timelines for the transfer of trainee allocation information to Human Resources and Educational Supervisors at least 12 weeks in advance of start dates so all training and induction formalities can be arranged.	Recommendation
1.5	**Handover** **Surgery** The visit team heard that there was a formal 8am handover meeting which involved the on call, night team and incoming team. The surgery trainees did not always attend handovers, the consultant or another higher trainee would contact the relevant trainee if necessary. The higher surgery trainees reported that they made a note of the events over a weekend if they were on call and then handed over on the phone to each department. There was a face to face handover meeting in the ITU where the higher trainee and core trainee or Trust fellow equivalent handover at 8am. The visit team heard that not many patients were admitted overnight; if patients were expected then most trainees waited for the patient. If the trainees did need to leave they contacted the on call team to ensure they were aware of the patient's arrival. **Trust Wide Review** The visit team heard that the paediatric trainees attended the 8am and 8pm handover which was a joint handover in a designated room which attendees signed in and out of. The handover was not provided in a written format.	The Trust should implement an auditable and documented handover system across the Trust that all trainees attend.	Mandatory Requirement
1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience**	The Trust is required to review and present the audit related to the WHO checklist completion and disseminate the learning from the	Mandatory Requirement

	The visit team heard that the WHO checklist was followed by all trainees and staff. However some trainees commented that the surgeons did not carry out the checklist until the patient was under anaesthesia. As a result of the never event, involving a mismatch of labelling of a surgical site and amputation, the visit team understood that the surgical WHO checklist had been reviewed. The visit team was told that the consultant surgeons at the Trust were approachable and provided feedback and support to all trainees.	investigation of the never event to all trainees and staff.	
1.7	**Adequate time and resources to complete assessments required by the curriculum** The visit team heard that all trainees were able to get work placed-based assessments signed off with ease as the consultants were all accessible.		
1.8	**Access to simulation-based training opportunities** The visit team heard that the simulation centre had recently opened and the Trust was looking at ways in which to maximise the use of the centre. The SMT indicated that when recruited the new DME position would have an important role in maximising the use and resource of the simulation centre. The visit team heard that currently the simulation centre was only being used for a couple of hours per week. The Trust stated that the director of medical education would be the lead and drive the use of the simulation centre. The Trust reported that they were currently reviewing the use of simulation for local teaching programmes. The visit team was told that there had been no simulation sessions for trainees to learn from serious incidents. The visit team was informed that Mr Julian Leong (Surgical Tutor) had offered sessions for trainees in the simulation centre. However, the anaesthetic trainees were not aware of there being a simulation centre within the Trust. The clinical supervisors commented that they would like to undertake simulation training with the trainees; the issue was regarding the logistics of arranging sessions and programmes for the trainees to partake in. The clinical supervisors would appreciate knowing what trainees they would be receiving three months in advance to assist in the planning of simulation sessions. The anaesthetic educational supervisors commented that they had not had any sessions in the new simulation centre. The department was looking into the provision of anaesthetics equipment so the simulation centre could be utilised. The visit team felt that the increased use of the simulation centre would enable core surgery trainees to meet some of the general trauma numbers as some of these numbers could be counted through simulation activity.	The Trust is to identify a lead for simulation, administrative support and set up programmes that are (a) specialty-specific, (b) team-based and (c) multi-professional providing access to all trainees and staff.	Mandatory Requirement
1.9	**Organisations must make sure learners are able to meet with their educational supervisor on a frequent basis**		

	The visit team heard that all trainees were able to meet with the assigned educational supervisor and discuss the learning agreement.		
GMC Theme 2) Educational governance and leadership			
2.1	**Effective, transparent and clearly understood educational governance systems and processes** The Trust reported that they had a developed a greater focus on education and through this had formed a multi-professional education committee. The committee was scheduled to meet every two months and would have rotating chair persons. The visit team was informed that all education matters would be raised at the committee meetings and would cascade directly into the Trust board. The Trust confirmed that the recruitment process for a new director of medical education was under way, at the time of the visit. The interviews were planned to take place just before Christmas 2015. The Trust commented that they had appointed a junior doctor as an associate medical director, who was a non-trainee to empower the junior doctor workforce. The associate medical director would focus on audits and the modernisation of the medical workforce.	The trust is required to produce an educational strategy that review the educational governance structure, terms of reference of local faculty groups, formal appointment of trainee reps and collate minutes of regular meetings.	Mandatory Requirement
2.2	**Impact of service design on learners** The visit team was informed of the plans to redevelop the Stanmore site. The redevelopment of Stanmore was granted full planning permission and would be completed in phases, with phase one commencing in 2016/17. Phase one would include a new ward block, bio-engineering hub, accommodation block for patients' families and rehabilitation facility for spinal patients. The Trust reported that the redevelopment would take place over the next 10 years. The Trust planned to improve local transport links to the Trust in the next three years. The visit team was told that the transport links were limited and there was never usually space in the car provided by the Trust from Stanmore tube to the Trust. The visit team heard that the site could take some time to navigate at night, though the trainees did not feel there were any concerns regarding walking around at night alone. The visit team was told that if a trainee did not want to walk alone at night they could contact security or the site manager to accompany them. The visit team heard that paediatric trainees had limited autonomy over patients regarding management decisions.	The Trust is required to ensure that all service reconfiguration and development plans include an assessment of the impact and opportunities on trainees and involve the DME and HEE stakeholders wherever possible.	Recommendation
2.3	**Appropriate system for raising concerns about education and training within the organisation** The surgery and anaesthetic trainees were unaware of the Trust local faculty groups (LFG).		

	The visit team heard that the Trust local faculty group met every three months. There were no discussions around each trainee, only trainees in difficulty.		
2.4	**Systems and processes to make sure learners have appropriate supervision** The surgery trainees reported that the consultants were accessible within the department and could be approached for help. If the trainee needed support they were able to telephone the consultants.		
2.5	**Systems to manage learners' progression** The Trust commented that they recognised the need to improve the experience and educational opportunities available within core surgical training. The Trust reported that they were in early discussions with other organisations and working with the Lead Provider, UCLPartners network to provide trainees with opportunities to undertake some core surgery curricula requirements at other organisations. The trainees were not aware of there being a management programme or opportunities within the Trust. The visit team felt this would be useful as most trainees were in the end stages of the training programme.	The Trust is required to develop leadership and management opportunities formally for all higher trainees as per curriculum requirements.	Mandatory Requirement
GMC Theme 3) Supporting learners			
3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The visit team heard that the library was operated under a University College London library service contract. The library manager reported that the library team participated in all inductions and provided trainees with packs containing information regarding open times, registering for library membership and contact numbers. The library manager commented that the library had three computer terminals and access to 40,000 electronic subscriptions through University College London (UCL), these documents could not be accessed remotely. The Trust also had its own Athens account which trainees registered for, this provided resources at local, regional and national level and could be accessed remotely. The visit team was informed that the library would be based in the new UCL building following the Stanmore redevelopment and would be closer to the acute hospital and outpatients.		
3.2	**Access to study leave** The visit team was informed that there were no issues regarding booking study leave, as long as the trainees gave enough notice.		
GMC Theme 4) Supporting educators			

4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The educational supervisors reported that they did not receive a set educational appraisal; it was however covered in the annual consultant appraisal. The educational supervisors were unsure who they would contact within the educational department for support and advice.	The Trust is required to ensure that the new DME is supported to establish faculty development, educational appraisal of all supervisors and along with the medical director have an overview of job plans to include educational tariff at 0.25 programmed activities per trainee.	Recommendation
4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The Trust commented that the training programme director (TPD) for surgery had reduced clinical commitments to support the role. The Trust had recruited more consultants into the TPDs unit to provide backfill so that educational activities could be fulfilled. The visit team heard that the TPD required further support in pre-planning the educational activity and timetable within adequate time. The visit team felt it was not clear whether educational supervisors received 0.25 programmed activities (PA) per educational supervisee. The visit team heard that most educational supervisors made time in their schedule to review the curriculum with trainees. The educational supervisors in anaesthetics and chronic pain had time in the job plans to carry out educational supervision roles.		
GMC Theme 5) Developing and implementing curricula and assessments			
5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** **Surgery** The Trust commented that within surgery they had 17 fellows across all units; most of the fellows were post-certificate of completion of training, 20 higher trainees and one core trainee. The visit team heard that the Trust had rejuvenated the core trainee teaching programme, which was on a Thursday morning. The programme was available in advance and on the intranet and trainees' attendance was monitored. The visit team heard that there was a Friday morning x-ray meeting with the bone tumour team to go through all in-patients, this was felt to be a useful learning tool. The trainees would then partake in a ward round followed by a multi-disciplinary team (MDT) meeting. The visit team heard that within the bone tumour unit there was a pre-operative MDT meeting with oncologists and radiologists every Friday morning for four hours. The meeting had a video link to the University College London oncology department. The MDT saw a vast amount of patients into the 100s and it was felt by the visit team that the large number of cases was not a suitable amount	The Trust is to review the structure of the multi-disciplinary team meetings within surgical disciplines and ensure that they provide educational opportunities.	Mandatory Requirement

	of patients to review and provide the trainees with educational opportunities to discuss cases in further depth. The visit team heard that trainees were able to attend anatomy teaching. The visit team heard that the trainees were involved in clinics and saw patients before discussing the cases with the consultant. However, the trainees would like to have access to consultant teaching clinics where they could observe. The higher surgery trainees reported that they could attend MDT meeting and departmental teaching. The trainees reported that they would like the teaching to be focused and on set topics each week. The spinal trainees commented that they did not receive departmental teaching on a Monday. The consultant who led the teaching was unavailable due to clinical commitments. The spinal trainees reported that the MDT clashed with the team clinic, which meant that trainees could not always attend the MDT as they had to start clinic. The visit team heard that most surgery trainees reported cases in the logbook as purely assisted when they had actually performed part of the surgery. The visit team was told that the surgery trainees in the reconstruction unit were exposed to significantly complex cases, which they could assist in. The reconstruction unit was happy for trainees to review any work undertaken within the department and observed the vast range of operations within the unit. The visit team was told that the reconstruction and shoulder department carried out pre-operative ward rounds with radiology, medical microbiology and virology and infection nurses, which were used as an educational opportunity for the surgery trainees. The educational supervisors informed the visit team of the higher trainee local teaching programme which included weekly interactive sessions, tutorials and teaching sessions led by a multi-professional team member. The visit team was informed that the surgical tutor made all new trainees aware of the teaching clinics and theatre lists which were available in the teaching centre on a poster. The visit team was told that there were opportunities for project and research work at the Trust. The trainees supported initial proposal submissions to ethics and the background research work and then would assist on the lengthy data collection. **Anaesthetic** The anaesthetic trainees reported that they had departmental teaching every Wednesday morning. The visit team was informed that this teaching was bleep-free as the consultant would cover the bleep. The trainees praised the teaching programme, the trainees felt the department took it very seriously and were committed to training. The visit team heard that the anaesthetic department had sessions within the department on critical incidents and airway training.	All departments are to review and publish lists of the teaching clinics offered to trainees and formalise these. The Trust is to reinstate spinal department teaching. The Trust should ensure that this is regularly attended by trainees, has consultant presence and is bleep free.	Mandatory Requirement Mandatory Requirement

	The trainees reported that they had been involved within audits and the consultants were proactive in providing opportunities to trainees. The chronic pain educational supervisors commented that they were able to offer training at all levels of pain training. The pain trainees were not included in the on call rota as the work of pain was different to the rest of anaesthetics. **Trust Wide Review** The paediatric trainees commented that the role was unusual as the trainees had no ownership of patients as they were admitted under the consultant surgeons' name. The visit team heard that the roles were not general paediatric roles as there was no emergency department. The trainees' main role was to provide pre and post-surgery support on the ward. The visit team heard that histopathology at the Trust was a niche area. The support was excellent and there were plenty of opportunities to participate in research and audit. The trainees worked closely with consultant pathologists and partook in histopathology reporting, requesting special stain and molecular studies. The rehabilitation medicine trainees reported that they enjoyed the post. The trainees shadowed a consultant in neurosurgery rehabilitation and attended chronic pain and neurological clinics. The visit team heard that the trainees covered all the curriculum requirements within the post. The visit team heard that the rheumatology trainees obtained a wide range of experience at the Trust. The trainees were exposed to unusual metabolic bone problems, interpreting scanning and hormonal metabolic tests. The rheumatology posts also worked within sport and exercise medicine and met inflammatory and mechanical problems in the musculoskeletal system. The rheumatology trainees had an inpatient ward with 12 beds; the ward only operated five days a week. The visit team heard that there were limited research opportunities outside of surgery. The consultant body was becoming more engaged and was keen to develop a bigger research profile.	The Trust should conduct a curricular mapping exercise for the higher paediatric training posts. This should outline what roles higher trainees would undertake and how this adequately meets competency requirements. It is suggested that the Trust work with the Head of School for Paediatrics to improve the practical experience of the trainees.	Mandatory Requirement
5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** **Surgery** The visit team was concerned to hear that not all the practical experiences required at core training were achievable at the Trust due to the complexity of most cases. The Trust did not undertake many routine minor operation cases that would be useful for core trainees. The visit team heard that the trainees reviewed new patients, followed up post-operative cases, attended clinics and a consultant would review the work undertaken. The visit team heard that trainees assisted on Tuesday operation lists. The higher surgery trainees reported that the case mix was beneficial, the senior support and understanding of cases that were rare was good. The trainees stated that they learnt a lot from	The Trust is to review the training experience and opportunity of core surgical trainees within the Trust to ensure curriculum requirements and exposure to emergency trauma surgery is also met. The core timetable needs reviewing to make the posts attractive through offering different educational experiences e.g. simulation. A programme is to be developed to	Mandatory Requirement

	surgeons who were well established in their field and felt they would be able to apply what they had learnt in the future. The visit team heard that there were increased consultant numbers and some cases that would have previously been undertaken by a higher trainee were now carried out by a consultant. The surgery trainees commented that the downside to the training was that there were no trauma cases. The higher surgery trainees stated that in a week they attended theatres, day ward rounds, clinics, planning meetings and MDTs. The visit team was told that some theatre lists were ran on the same day which meant trainees did not have the opportunity to observe all theatre lists. The surgery trainees reported that they were heavily involved in the pre-planning of complicated patients and pre-assessments. The visit team heard that 10 theatres were used Monday to Saturday with up to three sessions per day till 8.30pm and two sessions on a Saturday. The visit team was told that there had been discussions between educational supervisors regarding the core training programme and implementing a programme like the 'old-fashion SHO scheme' where trainees went to a specialist unit and undertook trauma elements at a different Trust. **Anaesthetic** The anaesthetic trainees were complimentary of the experience, range of cases and technical exposure they received at the Trust. The trainees on the three month rotation did not feel there was always enough time at the Trust to make the most of the opportunities available. **Trust Wide Review** The paediatric trainees commented that they undertook ward rounds and provided opinions for surgical complications. The trainees had allocated time in clinics in an observation capacity. The visit team heard that outpatients were very busy at the Trust and there was no space for a paediatric trainee clinic. The paediatric trainees did not always have enough tasks to undertake so were involved in quality improvement projects and research. The visit team heard that the paediatric department had gradually developed clinics and each consultant saw children with rare conditions. The paediatric department liaised closely with adult colleagues to open up opportunities. The visit team was told that paediatric trainees attended MDTs, X-ray meetings, child protection and safeguarding meetings. The rehabilitation medicine trainees reported that they attended chronic pain meetings on Tuesday afternoon with consultant input. The visit team heard that the rehabilitation trainees would like to be more involved in joint examinations and observe clinics. The visit team felt that a hospital-wide grand round would be a beneficial educational opportunity	show how the Trust will ensure training needs are met by the end of January 2016. The Trust is required to establish a multi-professional grand round weekly which would be managed by the Education department and provide a focus for the different specialities to interact and create a culture of shared learning.	Recommendation

	for all the trainees at the Trust. The rheumatology trainees were based mainly in sport, metabolic and general rheumatology clinics. The trainees had protected time for learning and in post-operative clinics the trainees reviewed the patients with consultants.		
5.3	**Opportunities for interprofessional multidisciplinary working** The Medical Education Manager (MEM) informed the visit team that the Trust had hosted a two day multi-professional faculty learning session for education leads. This workshop was to review the different ways in which people learn and how cross-department interactions could be improved. The anaesthetic trainees reported that a pharmacist had requested to attend their local teaching as they had heard it was good and would like to be involved. The rheumatology trainees regularly worked alongside occupational therapists, physiotherapists and nurses.		
5.4	**Appropriate balance between providing services and accessing educational and training opportunities** The visit team was informed that the onus was on service provision and not training and education. Due to the complexity of the cases at the Trust this resulted in trainees partaking in less than half of the operations in their department. The visit team felt that the trainees did not always feel they were able to be as involved as they would like.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**
The bleep-free teaching programme for anaesthetic trainees. The weekly lunchtime bleep-free teaching programme for core trainees. The specific paediatric induction for anaesthetists covering common paediatric emergencies.			

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

Signed	
By the Lead Visitor on behalf of the Visiting Team:	Dr Indranil Chakravorty, Trust Liaison Dean, Health Education England North Central and East London

Date:	4 February 2016