QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Lewisham and Greenwich NHS Trust

Core Surgery, General Surgery, General Practice Surgery and Trauma and Orthopaedic Surgery

Risk-based Specialty Review

Quality Review report

Date: 17 May 2016

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	Lewisham and Greenwich NHS Trust was formed on 1 October 2013 after the dissolution of South London Healthcare NHS Trust (SLHT). The Trust provided a wide range of acute healthcare services to the London Boroughs of Lewisham, Greenwich and Bexley. These boroughs were served by the Queen Elizabeth Hospital (QEH), University Hospital Lewisham (UHL), Queen Mary's Hospital (QMH) and community services within Lewisham. The Trust also worked in close collaboration with King's Health Partners (KHP) to provide local clinical services, research, education and training. In 2014/2015, the Trust provided over 520,000 outpatient appointments, over 60,000 emergency admissions and 5,000 elective admissions and reported having 5,800 permanent staff as well as 1,447 part-time staff. Following a review of patient admissions and monitoring for people in critically ill or unstable conditions, the Critical Care Unit at QEH expanded from 15 beds to 18 beds in 2014/2015. During the same period, the Trust increased its surgery sessions to meet the target for treating people within 18 weeks of referral. A surgical assessment unit had also been opened at QEH and UHL to improve the flow of patients within the Trust and a purpose-built surgical ward with the capacity of 20 beds at UHL had allowed the Trust to consolidate surgical services including elective surgical cases from QMH. In the 2015 General Medical Council National Training Survey, the Trust generated red outliers in the following areas: • **Core Surgical Training:** 'supportive environment' and 'workload'. • **General Practice Programme – Surgery:** 'clinical supervision' 'clinical supervision out of hours', 'supportive environment' and 'educational supervision'. • **General Surgery:** 'overall satisfaction', 'adequate experience' and 'access to educational resources'.
Specialties / grades reviewed	**Core Surgery, General Surgery, General Practice Surgery – University Hospital Lewisham site** The visit team met with five trainees in general surgery, trauma and orthopaedic surgery (T&O) and general practice (GP), including ear, nose and throat (ENT), at grades foundation year 2 (F2), core trainee year 1 (CT1), and speciality training ST2 (GP) The visit team also met with five higher trainees in general surgery covering both upper gastrointestinal (UGI) and lower gastrointestinal (LGI) surgery at grades ST3, ST4 and ST5. **Trauma and Orthopaedic Surgery - University Hospital Lewisham and Queen Elizabeth Hospital sites** Additionally, the visit team met with five higher trainees in T&O based across the UHL and QEH sites at grades ST3 and ST4.
Number of trainees and trainers from each specialty	**Core Surgery, General Surgery, General Practice Surgery - University Hospital Lewisham site** The visit team met with eight clinical and educational supervisors including colorectal, ENT and general surgeons. **Trauma and Orthopaedic Surgery - University Hospital Lewisham and Queen Elizabeth Hospital sites** The visit team met with five T&O clinical and educational supervisors as well as

	the college tutor.
Review summary and outcomes	The visit team identified a number of areas that were working well at the Trust, including the following: • The surgical ENT service had made significant improvements since the previous visit and the trainees reported a positive training experience. • The ENT induction was noted to be good practice as it included a clinical induction. • Regarding general surgery and T&O, work based assessments were completed and careers advice was given. • The visit team heard that the level of consultant cover and supervision was good, particularly within T&O. • Regarding T&O, the visit team heard that Mr Bajaj was an excellent trainer who did extra training at the QEH every fortnight which trainees from all sites attended. In addition, the visit team also identified a number of areas for improvement, including: • Although the ENT service was working well, the week on call system needed to be reviewed. • The visit team heard that the GP trainees were not always able to attend Vocational Training Scheme (VTS) training but it was unclear whether this was a rota issue or due to trainees. The Trust should ensure that trainees are released for VTS training. • Regarding core trainees in general surgery, the visit team heard that there were not enough surgical cases appropriate for the stage of training. As a result, the Trust was informed that from October 2016 the Training Programme Director would be allocating one core trainee from general surgery into the T&O service instead. • The visit team heard that there were not enough colorectal surgery cases to sustain three trainees. The visit team also heard that the Upper GI cases were not adequate to sustain three trainees particularly as the bariatric cases are performed by two consultants. The visit team confirmed that two trainees would be removed from the general surgery service and that the TPD would not allocate two from October 2016. • This would enable the department to rectify the situation for the following year and ensure that trainees obtain more laparoscopic training experience recorded in their log books. The Trust should ensure that all trainees were able to attend an induction, even if they start mid-rotation (e.g. from maternity leave). • The visit team heard reports that the behaviours and attitudes of one or two of the consultants within general surgery generated an atmosphere that was described as hostile. • Regarding general surgery, the visit team heard that there were many issues relating to the rota and some of these resulted from the lack of training opportunities across all grades. Furthermore, trainees did not receive their rota six weeks in advance. The visit team was informed that a higher trainee coordinated the rota but that too many consultants provided feedback and were involved in the allocation of lists to trainees. • The visit team heard that the intensity of the T&O timetable at the QEH site was heavy with no time for academic activities including audit and research work. • The visit team heard that there was limited theatre access for consultants based at the QEH site when working at the UHL site which impacted on

	their trainees. The visit team was informed that there was a business case in progress for vanguard theatre space to be utilised by consultants from all sites, which may improve the situation. • The visit team heard that surgical lists were starting late and that the Trust was looking at ways of increasing productivity by increasing the number of joint replacements per list i.e. to four and that this would have a negative impact on training. The visit team suggested that if they wanted to improve, the Trust needed to start their lists earlier and potentially extend to a three session day. An area of serious concern was also identified within T&O, as follows: • Despite presenting at the Emergency Department (ED) with a fracture, some patients were not seen in the fracture clinic for up to two weeks due to a large backlog of patients. The Trust was informed that the situation would be escalated to Care Quality Commission (CQC).

Quality Review Team			
Lead Visitor **(T&O session)**	Professor Nigel Standfield, Head of London Specialty School of Surgery	**Lead Provider Representative**	Miss Avril Chang, Training Programme Director for General Surgery
Lead Visitor **(Core Surgery, General Surgery, General Practice Surgery session)**	Professor Tim Allen-Mersh, Chair for the Regional Specialty Training Committee	**Core Surgery External Representative**	Mr Peter Hardee, Oral and Maxillofacial Surgery Consultant
T&O External Consultant	Mr Dominic Nielsen, Consultant Orthopaedic Surgeon, St George's University Hospitals NHS Foundation Trust	**Lead Provider Representative (Core Surgery)**	Miss Stella Vig, Training Programme Director (South West London)
GP Representative	Dr Sarah Divall, Associate Director for General Practice	**Lay Member**	Kate Rivett, Lay Representative
Scribe	Kate Neilson, Learning Environment Quality Coordinator		

Findings

GMC Theme 1) Learning environment and culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Ref	Findings	Action required? Requirement Reference Number
S1.1	**Patient safety** The visit team was informed by the higher trainees in T&O as well as the clinical supervisors that there were instances of patients presenting to the ED with fractures who were then not seen in the fracture clinic for up to two weeks, due to a large backlog of patients. It was noted that this could be a patient safety issue and that it had been added to the Trust's risk register. The Trust was informed that the situation would be escalated to Care Quality Commission (CQC).	Yes. See S1.1 below.
S1.2	**Serious incidents and professional duty of candour** The visit team heard from the higher trainees in T&O that although some of them had submitted Datix reports, they had not received any formal feedback. However, these trainees reported that incident reporting was discussed at teaching sessions.	Yes. See S1.2 below.
S1.3	**Appropriate level of clinical supervision** **University Hospital Lewisham site** **General Practice Surgery / Ear, Nose and Throat Surgery** The visit team heard from the foundation and core trainees in GP with experience of ENT that they felt well supported, especially by the higher trainees. These trainees reported that they were supported in ENT clinics and could always ask a senior colleague for advice. At night the senior was a non-resident but could get to the site within thirty minutes. Otherwise, an anaesthetist could be consulted when urgent advice was required. The visit team was informed by the core trainees in GP with experience of ENT that they were contacted in the case of an ENT emergency and not the higher trainees. The core trainees would then contact the higher trainees, if needed. The core trainees reported that they received a lot of phone calls requesting ENT advice, including from GPs asking for emergency appointments. The visit team heard from the core trainees in GP that at the time of the visit, a new email system had been implemented and they were hopeful that this would improve the situation and that they would get less calls for appointments. The visit team noted that the supervision of trainees in GP surgery had improved considerably and was now rated as good since the red outlier within this area in the GMC NTS survey in 2015. **Queen Elizabeth Hospital site** **Trauma and Orthopaedic Surgery**	

	The higher trainees in T&O informed the visit team that their clinical supervisors were very supportive of training opportunities. These trainees reported that they never had any issues with obtaining clinical supervision. Regarding weekend operating lists and supervision the higher trainees told the visit team that if not onsite, consultants would have come in if requested. Additionally, if not already onsite, anaesthetics consultants could be called upon at weekends if required. The visit team heard from the higher trainees in T&O that there could be issues with a lack of theatre space for general surgery and T&O cases at weekends.	
S1.4	**Rotas** **University Hospital Lewisham site** The visit team heard from the foundation and core trainees that the on-call rota varied in manageability. The trainees in T&O, based at the UHL site, also covered the general surgery on-call rota which could be extremely busy. The split in work was estimated to be 40% for T&O and 60% for general surgery. It was noted that there was not much major trauma work at the UHL site so core trainees had to see more minor trauma cases in order to achieve their competencies. It was noted that the ENT on-call rota was more manageable. These trainees suggested that the T&O and ENT rotas could be combined and have one rota for general surgery to ease the workload. There was a discussion about proposed changes to the GP surgery rota which, at the time of the visit, was due to include urology cover. The visit team confirmed that this was likely to involve trainees covering wards (but not urology patients within the ED) on a one in ten rather than one in seven basis. It was noted that the trainees covering the urology rota would need a separate induction in urology, as they may not have had experience in this area. General Practice trainees doing ENT and covering urology at night would benefit from being able to attend some urology clinics **General Practice Surgery / Ear, Nose and Throat Surgery** The trainees in GP surgery with experience of ENT informed the visit team that the training was good but that the on-call rota could be difficult as it involved working seven days in a row. These trainees were hopeful that the rota would change in August 2016. The visit team heard from the clinical supervisors that the ENT rota had previously been split into three and then four day stretches but that a previous cohort had requested it to include seven days in a row. The Trust confirmed that they would revert to the three and four day split from August 2016. The trainees in GP surgery reported that at the time of the visit, they had attended three out of the last seven VTS sessions which was noted to be inadequate by the visit team and may be indicative of the heavy rota. The college tutor confirmed that trainees were released to attend this training so this may be related to trainee choice. **Core Surgery / Trauma and Orthopaedic Surgery** The visit team heard from the core surgical trainees in T&O that they had had more experience in theatre, in some cases three times more, than their previous placements in general surgery at the Trust. These trainees reported that they had had experience of carpal tunnels, ankle fractures amongst other procedures and that they were achieving their quality indicators. They noted that there would be capacity for another core trainee within the service. The core trainees in T&O informed the visit team that they, rather than the higher trainee, would have to leave theatre to attend the ED if requested. It was noted that there could be inappropriate referrals from the ED due to a lack of clinical confidence of certain higher trainees in EM. This had been an issue especially at night. The core trainees in T&O also reported that they received frequent calls from nurse practitioners regarding fractures, and this added to their workload, which could have otherwise been managed by trainees and consultants within the ED. **General Surgery** The core trainees in general surgery based at the UHL site informed the visit team that	Yes. See S1.4a below.

	there were three operating lists a week and that they got to theatre at least twice a week. However they reported that surgical opportunities were limited due to the fact that most of the higher trainees were at a relatively junior level so they were reluctant to pass opportunities on to core trainees. These trainees noted that in the four months of their general surgery rotation, they had experience of twelve procedures. The visit team heard that there was an associate specialist surgical list but the core trainees reported that due to the small amount of work on this list, the higher trainee did the majority of it. The core trainees informed the visit team that the 'lumps and bumps' list provided a good learning opportunity as there were no higher trainees on this list but that as there were five core trainees, they had to rotate each week.	
	The core trainees reported that they were attracted to the Trust due to the opportunity to complete eight months of general surgery training but that they had not had a positive experience as the placement was not educationally balanced. The visit team heard that the UGI job provided more opportunities than the LGI job, partly due to the fact that there were only two colorectal lists a week. These trainees noted that changing the rotation so that there were six months of general surgery and six months of T&O may have improved the situation.	Yes. See S1.4b below.
	Upper Gastrointestinal (UGI) Surgery	
	The visit team was informed by the higher trainees within UGI that within the service, there were three consultants and an associate bariatric surgeon. However, it was noted by the higher trainees that at the time of the visit, the bariatric surgeon was training another consultant so this did not provide a training opportunity for trainees, except in terms of gall bladders and hernias. More experienced higher trainees were able to do more regarding assisting and mobilising of stomachs.	
	Regarding the associate specialist surgical list, there were opportunities for higher trainees to operate on hernias so this list provided a good training experience for higher trainees up to ST4 but not so much for higher trainees above this grade. The higher trainees in UGI reported that there was a lack of complexity of surgical cases in this area (mainly hernias and gall bladder work) which limited training opportunities. The visit team heard that consultants were not adverse to providing trainees with procedures but that there was not enough work. Additionally, the higher trainees noted that there were too many higher trainees for the amount of work within the department. It was noted that the way the on-call rota was scheduled did not help the situation and that it was hard to build a rapport with surgeons as there was little consistency on the rota. The visit team heard from the higher trainees that consultants were aware of the issue of workload and numbers of trainees.	
	The visit team was informed that although the higher trainee on the on-call rota was supposed to be a non-resident, this was not always the case as trainees could spend three or four hours onsite overnight. This was due to the fact that trainees did not dictate the rota and consultant expectations on higher trainees at the morning handover were high.	Yes. See S1.4c below.
	Lower Gastrointestinal Surgery	
	The higher trainees informed the visit team that the rota coordination for the colorectal surgical lists was difficult due to the low volume of cases at the site and large number of trainees.	
	The visit team was informed by the higher trainees that within the colorectal service, there were three consultants. However it was noted by the higher trainees that at the time of the visit, two of the colorectal consultants were themselves still in the learning curve for laparoscopic colorectal surgery and there were minimal opportunities for the trainees to gain any experience in laparoscopic colorectal procedures. The visit team heard that these two colorectal consultants did provide good training for other surgical procedures which were not colorectal resections.	
	Ms. Linsell was identified as an excellent trainer for open colorectal surgery and general surgery.	
	In terms of clinical commitments, the visit team heard that there were six clinics a week between four higher trainees. It was noted that patients were consented in clinic by the consultant as well as prior to the procedure.	Yes. See S1.4d below.

	University Hospital Lewisham and Queen Elizabeth Hospital sites **Trauma and Orthopaedic Surgery** The visit team heard that there were eight T&O consultants based at the QEH site and seven (soon to be nine) at the UHL site. Consultants moved between the three sites (UHL, QEH and QMH) and following the merger consultants from the QEH site were not allocated any lists at the UHL site, which the Trust recognised was an error and at the time of the visit, plans were in place to increase operating capacity at this site. The visit team was informed that a business case for vanguard theatre space (to be utilised by consultants from all sites) had been submitted for Saturday operating lists on the UHL site but that a lack of anaesthetists and beds had made this difficult. Furthermore, the visit team heard that there was a culture of starting surgical lists late which meant that consultants rushed to finish these lists and therefore lost training opportunities. At the QEH site, there were trauma lists on a Monday to Saturday so trainees got sufficient trauma experience at this site. The higher trainees reported having had a positive experience at the QEH site as there was a high volume of trauma work so they had met their quality indicator numbers within 18 months of their two year placement. The higher trainees in T&O noted that although there was enough work for them, their training experience would be improved if there was more of a mixture of trainees, including higher trainees at ST5 and above. Furthermore these trainees reported that the T&O placement at the Trust could be improved by spending one year at the UHL site and the second year at the QEH site. The higher trainees in T&O told the visit team that they would recommend the UHL site as a good place to train for the early stages of training but that opportunities were limited for higher trainees.	Yes. See S1.4e below.
S1.5	**Induction** The visit team was informed by the trainees at all levels that the majority of them had received an induction. The specialty trainees in GP reported that they received an ENT induction at the beginning of their rotation which took place on one day, as it was affected by the recent strike action. The trainees reported that regarding the induction, teaching was good and that they felt well prepared for on calls. They were shown how to pack at induction, so included a clinical element. However, it was noted that one trainee had missed the induction due to maternity leave and started their rotation on call.	Yes. See S1.5 below.
S1.6	**Protected time for learning and organised educational sessions** The visit team heard from the higher trainees in T&O that they had no issues with attending regional teaching and obtaining time off for this purpose, despite this area having raised a red flag in the GMC NTS in 2015. The higher trainees in T&O informed the visit team that the internal fortnightly mid-week teaching at the QEH site by Mr Bajaj was very good and attended by trainees from all sites. The core trainees in general surgery reported that monthly Morbidity and Mortality (M&M) meetings were held and alternated between the UHL and QEH sites. It was noted that it could be difficult for those trainees based at the UHL site to attend when these were held at the QEH site. The trainees informed the visit team that issues were discussed in an open manner at these meetings.	
S1.7	**Adequate time and resources to complete assessments required by the curriculum** The trainees reported that they had received workplace based assessments.	

GMC Theme 2) Educational governance and leadership		
Standards **S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.** **S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.** **S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.**		
S2.1	**Appropriate system for raising concerns about education and training within the organisation** The visit team heard from the core trainees that Local Faculty Group (LFG) meetings were not set up for surgery at the Trust but that the trainees felt it would be useful to have a structured environment to discuss issues with the consultant body. If these trainees had any issues with their training, they noted that they would speak to their clinical supervisors in the first instance. The core surgical trainees reported that there was a faculty meeting (although not an LFG) which was attended by a trainee representative but that this was not a specialty specific forum.	Yes. See S2.1 below.
S2.2	**Organisation to ensure access to a named clinical supervisor** The visit team heard from all of the trainees that they were allocated a clinical supervisor whom they had met at the beginning of their rotation and were planning to meet again.	
GMC Theme 3) Supporting learners		
Standards **S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.**		
S3.1	**Behaviour that undermines professional confidence, performance or self-esteem** **University Hospital Lewisham site** **General Surgery** The trainees at all levels in general surgery informed the visit team that whilst they had not personally experienced bullying behaviour, there was little pastoral care and a culture of hostility within the department. It was noted that raising concerns around patient care could lead to hostile comments from consultants, especially towards higher trainees. These trainees felt that this led to missed learning opportunities as some consultants were not open to explaining why a course of treatment was followed over another. Foundation and core trainees raised any concerns around patient care with the higher trainees who would then raise them with the consultants, due to more junior trainees feeling reticent to discuss issues with the consultants directly. The issue was reported to be around one or two consultants in particular. The trainees noted that they sometimes completed excessive or unnecessary tasks to placate difficult personalities but that they had no concerns around patient care. The visit team was informed by the trainees that the atmosphere within the general surgery department did not encourage them to go onto specialise in general surgery. The visit team was informed by the higher trainees that the rota coordination could cause problems as certain consultants made complaints that it was not properly	Yes. See S3.1 below.

	managed but did not communicate between themselves. The higher trainees noted that there was a monthly directorate meeting which was attended by the rota coordinator that would be a suitable arena to raise this issue of the rota with consultants. Although these trainees reported that it may be intimidating to discuss it with consultants present. It was suggested by the trainees in general surgery that the main issue could have been around the fact that trainees were moved around regularly so it was hard to develop relationships with consultants in the department. The visit team heard from the trainees based at the UHL site, that overall the site was a good place to work and that the nursing staff and consultant body were supportive in general. The trainees reported that they were informed at their induction how to escalate issues in terms of bullying and undermining behaviour but that they had not felt inclined to do so.	
S3.2	**Academic opportunities** The visit team was informed by the higher trainees in T&O that those based at the UHL site received half a day per week on their rota to complete administrative duties, such as signing letters. However the higher trainees based at the QEH site did not receive this allocation and reported that they would have liked to have had sessions to complete audit and research work.	Yes. See S3.2 below.
S3.3	**Access to study leave** The visit team heard from the trainees at all levels that there were no issues with obtaining time off for annual leave or study leave.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The visit team noted that the ENT induction constituted good practice as it included a clinical induction.	College Tutor	Please complete attached proforma and return to the Quality and Regulation Team.	1 July 2016

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
S1.1	The Trust is required to ensure that patients who present to the ED with a fracture are seen at the fracture clinic within a safe time frame, noting that the national standard is 72 hours.	The Trust must produce an audit of patients – discharge date and date of clinic attendance. If the results of the audit show inadequate patient follow-up times, a plan including time scales to be produced to indicate how the Trust will resolve this. The Trust must submit minutes from LFG meetings to demonstrate trainee feedback that this requirement is being met.	R1.5

S1.2	Trust to review and strengthen the serious incident process. Trust to ensure that all trainees who submit Datix reports receive feedback, including details of how the issue has been dealt with.	Trust to provide summary of feedback to trainees versus a log of Datix forms submitted by trainees. Trust to ensure that serious incident reporting is added as a standing item to the LFG meeting's agenda and register of attendance.	R1.3
S1.4a	Trust to conduct an audit on the number of GPVTS training sessions that GP surgery trainees do not attend and the reasons given.	Trust to submit copies of the audit and resulting plan from the audit. This should be corroborated by GP trainee feedback that they are able to attend weekly GPVTS training sessions at LFG meetings.	R1.12
S1.4b	Trust to review the workload within colorectal and Upper GI surgery to ensure that there is enough scope for sufficient training experience to sustain three higher trainees per firm, if the withdrawn trainee or trainees are to be reinstated in October 2017.	Trust to submit copies of the revised rotas for higher trainees in colorectal and Upper GI surgery which clearly demonstrates theatre time and time to meet curricular requirements, including the types of cases which the trainees can expect to do Compliance with this action should be monitored through LFG meetings.	R1.12
S1.4c	Trust to revise the general surgery rota and clarify the expectations on the higher trainee non-resident post. The Trust should ensure that trainees receive the rota at least six weeks in advance.	Trust to submit copies of the new rota as well as evidence that this had been sent to trainees at least six weeks in advance. Compliance with this action should be monitored through LFG meetings.	R1.12
S1.4e	Trust to ensure that within T&O, surgical lists start on time to maximise the amount of training opportunities available to trainees. Trust to consider potentially extending surgical lists to three sessions per day.	Trust to submit an audit of surgical list start times and an update on the viability of potentially extending theatre lists to include three sessions a day. Compliance with this action should be monitored through LFG meetings.	R1.12
S1.5	Trust to ensure that all trainees receive an induction, even those trainees who commence placement mid-year. The induction should cover lines of escalation so that there are clear pathways for trainees to raise concerns around undermining and inappropriate behaviours.	Trust to submit confirmation of induction arrangements as well as induction material. Trust to circulate an induction survey to trainees and submit feedback received. Performance of induction should be monitored through LFG meetings.	R1.13
S2.1	The Trust to implement quarterly sub-specialty LFG meetings within surgery to ensure that trainees have a forum in which to feedback issues regarding their training to the consultant body. LFG meetings should include clinical supervisors, educational supervisors, college tutor and representation of trainees at all grades. These meetings should be minuted including an action plan and a register taken.	Trust to submit a schedule of LFG meetings for the next 12 months and register, minutes and action plan from the next four meetings.	R2.1
S3.1	Trust to investigate the reports of the hostile environment within general surgery	Trust to submit a report on the actions taken to resolve the hostile environment	R3.3

	identified at the visit. Clinical leads should hold regular meetings with the trainees to confirm that the behaviours identified have been resolved.	reported within general surgery.	
S3.2	Trust to ensure that higher T&O trainees based at the QEH site receive a protected half-day a week session to complete academic work, including research and audits.	Trust to submit copies of the revised QEH T&O rota which clearly demonstrates the protected half-day a week session to complete academic work. Compliance with this action should be monitored through LFG meetings.	R1.12

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
S1.4d	The visit team recommends that the Trust should provide additional theatre space on the UHL site to facilitate the implementation of a regular weekend T&O trauma list on this site. This would involve work on ring fencing beds and ensuring that there are sufficient anaesthetists to man this additional space.	The Trust could provide a plan and an update on the progress of the vanguard theatre lists business case and how this will improve education and training opportunities.	R5.9

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

Requirement	Responsibility
Health Education England to inform the CQC of the patient safety issue concerning patients presenting at the ED with a fracture but not being followed up at the fracture clinic for up to two weeks.	Quality and Regulation Team (London and the South East)

Signed

By the Lead Visitor on behalf of the Visiting Team:	Professor Nigel Standfield, Head of London Specialty School of Surgery Professor Tim Allen-Mersh, Chair for the Regional Specialty Training Committee
Date:	21 June 2016