QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Whittington Health NHS Trust

Trauma and orthopaedics surgery

Risk-based Review (on-site visit)

Quality Review report

16 November 2017

Final Report

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Quality Review details

Background to review	The Risk-based Review (on-site visit) was prompted by the results of the 2017 General Medical Council National Training Survey (GMC NTS) for trauma and orthopaedic surgery at the Whittington. The Trust received red outliers for: supportive environment, educational governance, local teaching and regional teaching. A further six pink outliers were returned for: overall satisfaction, clinical supervision out of hours, induction, curriculum coverage, educational supervision and feedback. Health Education England (HEE) therefore felt it was necessary to undertake an on-site visit to explore the reasons behind the poor results that were received and ascertain whether the learning and training environment was suitable.
Training programme / learner group reviewed	Trauma and orthopaedic surgery
Number of learners and educators from each training programme	The quality review team initially met with the Medical Education Manager, the Director of Operations for Surgery and Cancer, the Clinical Director for Surgery and Cancer, the Surgical Tutor, the Director of Medical Education and the Medical Director. Subsequently, the team then met with 4 higher trauma and orthopaedic surgery trainees, from a number of training rotations, at grades between ST5 and ST8, and foundation trainees working within the trauma and orthopaedic department. Finally, the review team met with a number of educational and clinical supervisors within the department.
Review summary and outcomes	HEE would like to thank the Trust for accommodating the Risk-based Review (on-site visit) and ensuring that all the sessions were well attended. During the course of the review, the quality review team was informed of some areas that were working well in relation to the education and training of trauma and orthopaedic trainees: - The review team noted that the feedback that had been returned in the 2017 GMC NTS did not entirely match the impression that was returned from the trainees during the on-site visit. The trainees unanimously reported that there was a positive culture in place within the department, and that they felt well supported by the consultant body. The review team learnt that during the previous year, there were three less than full time trainees in the department which may have contributed to the poor results returned in the 2017 GMC NTS. - The higher trainees indicated that they received good training experiences and opportunities. The review team was informed that the higher trainees had good access to operative training and that the foundation trainees were also encouraged to attend theatre sessions. However, areas for improvement were also identified and highlighted as follows: - The review team noted from a pre-visit questionnaire that the previous cohort of trainees had often undertaken up to six or eight clinic sessions per week, which did not constitute good training. The cohort of higher trainees the review team met with reported that they were routinely undertaking three or four clinics per week, which the review team felt was a little more than the number the higher trainees should have been undertaking and not in line with the recommended guidelines from the

	Joint Committee on Surgical Training and the School of Surgery, which recommended that higher trainees should be typically undertaking two clinics per week (with a third if it represented a good, subspecialty educational opportunity). - The review team was informed that the majority of patients the higher trainees saw during clinics were follow up appointments, as opposed to new patients, which the review team felt needed to be addressed. Furthermore, it was reported that the higher trainee clinic list was fixed and needed to be covered if a trainee was on leave and continued if the consultant was away. It was recognised that this was purely service provision and that consistent, real time clinical supervision was not always provided. - The review team felt that as the sustainability and transformation partnership for trauma and orthopaedic surgery was in its early stages, it would be beneficial to review how referrals were triaged before they came to the department and to ensure that the department was more proactive in terms of discharge, to address the follow up to new patient ratio. - The junior trainees reported that there were a large number of gaps in relation to the out of hours, hospital at night rota. The review team was informed that the rota gaps were predominantly filled by locum doctors of variable quality who on occasion did not turn up for shifts. The review team requires the department to continue working towards embracing the extended surgical team in relation to covering the out of hours rota (e.g. physician associates, advanced nurse practitioners). Furthermore, the review team felt that a formal escalation protocol regarding what happens when a rota gap occurs out of hours should continue to be formulated, so trainees were aware of what they should do in such instances. - The review team felt that the Local Faculty Group (LFG) should be re-established and embedded in order to provide real time feedback from trainees regarding any issues in relation to education and training. The review team was encouraged to hear that a LFG was being planned at the time of the review, and encouraged the department to utilise the National Association of Clinical Tutors (NACT) model, to ensure that there was wide trainee representation.

Quality Review Team			
HEE Review Lead	Mr John Brecknell Head of the London Postgraduate School of Surgery Health Education England	**External Clinician**	Lieutenant colonel Mike Butler, Consultant Orthopaedic Surgeon and Trauma Lead - Royal Cornwall Hospital. Representing the SAC
Deputy Postgraduate Dean	Dr Andrew Deaner Deputy Postgraduate Dean Health Education England North Central London	**Deputy Postgraduate Dean**	Dr Gary Wares Deputy Postgraduate Dean Health Education England North Central London
London Specialty School of Surgery Representative	Mr Dominic Neilson Deputy Head of the London Postgraduate School of Surgery	**Scribe**	Elizabeth Dailly Deputy Quality and Reviews Manager Health Education England, London and the South East

Lay Member	Jane Chapman Lay Representative		

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement Reference Number
T&O 1.1	**Appropriate level of clinical supervision** The junior trainees commented that when they were undertaking out of hours shifts, during which they covered all of the surgical departments in the hospital (including general surgery, trauma and orthopaedic surgery and urology) sometimes it was difficult to contact the urology higher trainee who was on call. The review team was informed that on occasions they had attempted to contact the higher trainee on call through switchboard, but that they had not been able to get through. Otherwise the supervision arrangements appeared to be satisfactory.	Yes, see other actions below
T&O 1.2	**Rotas** When discussing rota gaps at the higher trainee level, the review team was informed that the one gap was covered by a regular locum, which worked well. However, in relation to the junior trainees' rota out of hours, which covered the whole surgical department, including trauma and orthopaedic surgery, general surgery and urology, the review team was informed that there was a high number of rota gaps, 3 within the department itself at the time of the visit. The trainees reported that the posts were filled with locum doctors, but that often the department struggled to secure cover, as the rate of pay offered was similar to that provided for day shifts and therefore did not provide a great enough incentive. Furthermore, the trainees indicated that often the locums did not arrive for their shifts without giving notice, leaving the department without a basic grade doctor overnight. The review team was informed that when this occurred, there was no formal escalation policy in place regarding how the situation should be managed, which trainees felt would be beneficial. The higher trainees confirmed that when this had occurred they had not been asked to act down and that their on-call shifts were non-resident. The educational and clinical supervisors reported that when	Yes, please see T&O1.2a

	there was no cover out of hours, new patients were reviewed in the medical and surgical assessment unit within the emergency department and that the wards were covered by the on-call medical team. However, they confirmed that no structured escalation policy was in place. It was reported by the supervisors, that they had tried to recruit to the empty posts but that at the time of the review, had been unsuccessful. The visiting team raised the idea of the department employing members of the extended surgical team, non-medical practitioners undertaking roles traditionally allocated to doctors, to reduce the workload out of hours and the consultant trainers seemed open to exploring the possibility of recruiting advanced clinical practitioners and physician associates. Furthermore, the review team was informed by the trainees that the quality of the cover provided by locums out of hours was variable, which was confirmed by the consultants. However, the supervisors commented that the cover had improved over the recent month, by ensuring that locum cover was provided. The review team was informed that the problems in relation to adequate foundation and core level cover out of hours was likely to be exacerbated in the upcoming winter months, as there were potential plans for the surgical out of hours cover to also be used to provide cover to medical outliers on the surgical outlier ward. The educational supervisors reported that this would have a further negative impact upon the core and foundation trainees' already onerous workload and put more pressure on the department and trainees, as well as limiting the surgical teaching and training they received during their placements. The higher trainees confirmed that they had an administration day included in their timetable each week. Some of the foundation trainees indicated that they had exception reported whilst undertaking their placement, and reported that although they had not received feedback they had been subsequently reimbursed for their time.	Yes, please see T&O1.2b Yes, please see T&O1.2c
T&O 1.3	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The higher trainees reported that they all typically accessed three or four operating sessions per week with their designated consultants. These lists comprised a mix of trauma and elective operative experience. The trainees stated that they received excellent training opportunities and that clinical supervision was always provided during theatre lists as the consultant was always present. The foundation trainees reported that although theatre sessions were not included in their rota, they were encouraged to attend on a weekly basis by the consultants within the department and that typically they attended one theatre list per week. In relation to clinics, the higher trainees commented that they routinely undertook three or four sessions per week and that the typical number of patients they saw during each clinic varied, but on average was around 12 per clinic template. However, the review team was informed that during the fracture clinics, the trainees were sometimes expected to see up to 18 patients. The trainees reported that they were able to access clinical supervision and consultant advice whilst in clinic and that if they asked, the consultant would be present when they were reviewing a patient. The review team was informed that often during clinics, the trainee and consultant worked out of one clinic room, with two examining rooms, which worked well and ensured that adequate supervision was provided. The trainees reported that the majority of the patients they saw during clinics were for follow up appointments, as opposed to new patients, which the trainees would have found more educationally valuable. The review team was informed that the higher trainees typically saw only one or two new patients each clinic, which they then presented and discussed with their consultant. This was confirmed by the educational and clinical supervisors, who reported that the trainees regularly saw two new patients each clinic, depending on how busy it was.	

	The review team was informed that if the higher trainees' primary consultant who they undertook the clinics with was on leave, that the consultant's patient list was cancelled, but that the higher trainees schedule still ran and they had to see patients. The trainees reported that as there was usually another consultant undertaking a clinic simultaneously, they could access clinical supervision if necessary and that the consultants were extremely approachable and happy to provide advice. The higher trainees further commented that if they had any specific questions for their consultant they would take a note of the patients details and discuss them with the consultant when they returned. Overall though the visiting team learnt that the clinical workload for higher trainees was greater than was ideal for their training and that much of that workload was of limited educational value. The foundation trainees indicated that the consultants in the department encouraged them to attend clinics and that they typically attended on a weekly basis. This involved the trainees sitting in the sessions with the consultants and examining patients with the consultants present. The educational and clinical supervisors reported that as the higher trainees were from four different rotations, they met with the trainees before they began their placements to ascertain what areas they needed further experience in and what they wanted to get out of the post. The review team was informed that the trainees' timetables were then created accordingly.	Yes, please see T&O1.3
T&O 1.4	**Protected time for learning and organised educational sessions** The higher trainees reported that as they were all based on different surgical rotations, each rotation had a separate regional teaching session, which often covered different topics. The trainees indicated that they were able to secure study leave in order to attend their regional teaching sessions and that their consultants were happy to cancel their clinic lists in order for them to attend. Furthermore, the review team was informed that the consultants were happy to rearrange the order of patients on the theatre list in order for the trainees to attend their regional teaching. However, some trainees indicated that as their regional teaching sessions were held at the same time as one of their theatre lists, they often did not attend the teaching in order to gain further operative experience. The trainees reported that this was because they prioritised their operative exposure and that their consultants were happy for the trainees to attend their regional teaching as opposed to their theatre lists. The Surgical Tutor indicated that if the trainees were not able to attend their specific rotation's regional teaching, then they were able to attend one of the other teaching sessions for the different rotations. However, the trainees indicated that there was a lack of cohesion in regard to what was covered on each rotation's regional teaching sessions and that each rotation had a distinct and separate teaching programme. Therefore, in practice the trainees were unable to attend the other regional teaching sessions if they missed their specific session. Furthermore, the review team was informed that the trainees had to attend 70 per cent of their regional teaching sessions, and that attending sessions from other rotations would not count towards their percentage of attendance. The review team was informed that the daily trauma meetings and weekly metal work meetings provided some educational value as during them a wide range of pathologies and patient cases were discussed and the consultants provided feedback and constructive criticism.	
T&O 1.5	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** Trainees at all levels confirmed that they had been allocated an educational supervisor and been able to meet with them at the beginning of their placements. The trainees reported that they were able to organise meetings with them easily and complete their relevant workplace based assessments and supervised learning activities. This was confirmed by the supervisors, who reported that they regularly met with the trainees to go through their portfolios and discuss any issues they had.	

	The review team was informed that due to the 'firm' structure that was in place within the department, the educational and clinical supervisors spent a lot of time with their designated trainee, and therefore provided both formal and informal teaching on a daily basis. The 'firm' structure also ensured that adequate clinical supervision was provided for trainees.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

T&O 2.1	**Appropriate system for raising concerns about education and training within the organisation** The trainees reported that they were aware of the trainee forums that took place within the Trust, but reported that they had not attended. The clinical and educational supervisors reported that there had not been a local faculty group (LFG) meeting during the months preceding the review. However, the review team was informed that the meetings were being reintroduced and a meeting was being organised for the following month, to which all trainees would be invited to provide feedback. The Surgical Tutor confirmed that this would take place during the audit day, to ensure there was greater attendance. The hiatus in LFG meetings may go some way toward explaining how the NTS results caused a degree of surprise amongst the trainers in the department.	Yes, please see T&O2.1
T&O 2.2	**Systems and processes to identify, support and manage learners when there are concerns** The review team was informed that when there was a trainee in difficulty within the department, their relevant educational supervisor met with them daily in order to discuss any issues and ensure they were okay. The review team was informed that they received information on the trainees' progress from a number of members of the department and escalated any concerns regarding higher trainees to the training programme director. In relation to foundation and core trainees, the educational and clinical supervisors reported that they would discuss any issues with the Director of Medical Education, who was extremely supportive.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.		
T&O 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** Trainees at all level reported that they were working within a positive culture. The higher trainees reported that they felt valued as team members and that the consultants within the department were approachable and supportive. The foundation trainees similarly stated that they felt the culture was positive and supportive. They stated that they were encouraged by the consultants to attend theatre sessions and that they had built good relationships with their clinical supervisors.	
T&O 3.2	**Access to study leave** The review team was informed that one of the higher trainees was in charge of the higher trainee rota, with oversight from one of the consultants within the department. The trainees reported that as only two higher trainees were allowed to be on leave at the same time, this had resulted in requests for leave being rejected. However, if two higher trainees were already on leave, and a third requested leave on the same dates, the review team was informed that this request would then go to the consultant with oversight of the rota who would sometimes make exceptions, and examples were provided of when this had taken place. The foundation trainees confirmed that they had been able to secure annual and study leave and that this was managed through the surgical rota coordinator. It was reported that as previously there had been three less than full time (LTFT) trainees within the department, it had been challenging to manage the rota and ensure that all clinics were covered whilst allowing trainees to take study and annual leave. It was during this period that the 2017 GMC NTS was conducted.	
4. Supporting and empowering educators		
HEE Quality Standards **4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.** **4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.**		
T&O 4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The review team was informed that the medical education department was extremely supportive if any of the supervisors needed to undertake any courses in relation to their educational responsibilities.	
T&O 4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The clinical and educational supervisors the review team met with confirmed that they had the appropriate amount of supporting professional activity (SPA) time included within their job plans to undertake their educational duties and responsibilities.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The visiting team found a culture within the department which was highly supportive of training. Higher surgical trainees in the department had good access to operative training.			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
T&O1.2 a	The Trust should ensure that a formal escalation protocol is in place for the department to follow when a rota gap occurs out of hours, and that this is disseminated to all within the department.	The Trust to submit the escalation policy and copies of the correspondence disseminating the policy across the department.	R1.7
T&O1.2 c	The Trust should provide a report on the risk management of variable quality locums at the basic medical grade engaged within the surgical departments of the Whittington, with particular reference to the plan to reallocate foundation doctors in anticipation of the winter period.	We look forward to receiving the report.	R1.7
T&O1.3	The Trust should review the total number of sessions spent in clinic and the relative numbers of new and follow up outpatient consultations undertaken by trainees with a view to prioritising new patient consultations and aiming for work schedules which include only 2-3 sessions in clinic per week. They should also ensure that real time supervision is available for trainees undertaking outpatient work. This is likely to involve cancelling registrar lists when the consultant or the registrar are away.	Please provide a report on your findings and plans in this area, including a survey, conducted when plans are mature and in place, of the outpatient activity of the higher surgical trainees in trauma and orthopaedic surgery at the Whittington.	R1.15
T&O2.1	The Trust should ensure the local faculty group (LFG) is re-established and embedded within the department. These meetings perhaps work best when as many trainees as are available attend together with trainers and a management representative and can provide a tool for the detection and correction of training	The Trust to confirm that the LFG meetings are taking place within the department and provide minutes and registers of attendance.	R2.1

	issues as they arise. The National Association of Clinical Tutors (NACT) provides such a model.		

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
T&O1.2 b	The department is strongly encouraged to embrace the development of an extended surgical team, in order to support basic grade medical training by fully covering the workload involved in the care of the inpatient population (e.g by the recruitment and training of physician associates and advanced nurse practitioners).	We look forward to receiving an update on the department's arrangements regarding the recruitment and training of advanced nurse practitioners and other non-medical staff groups in the concept of covering the workload associated with the care of the TandO inpatient population.	R1.12

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The review team felt that as the sustainability and transformation partnership for trauma and orthopaedic surgery was in its early stages, there was a current and valuable opportunity to review how referrals were triaged before they came to the department and to ensure that the department was more proactive in terms of discharge, to address the follow up to new patient ratio.	Trust
The review team heard that the foundation doctors working with the Trauma and Orthopaedic team and attending the visit were sometimes unable to contact the urology registrar on call although supervision arrangements otherwise seemed satisfactory. Although this finding lies outside the scope of the visit, it will be passed on to the relevant Foundation School.	HEE LaSE

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Mr John Brecknell
Date:	07 December 2017

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.