Health Education England

King's College Hospital NHS Foundation Trust (Princess Royal University Hospital)

Trauma and Orthopaedic Surgery including Foundation and Core Surgical Training

Risk-based review (on-site visit)

Quality Review report

31 January 2019

Final

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Quality Review details

Background to review	Health Education England (HEE) planned this quality review based on the deterioration of scores for foundation year two (F2) surgery training, core surgical training (CST) and trauma and orthopaedic (T&O) surgery training at the Princess Royal University Hospital site (PRUH) in the General Medical Council National Training Survey (GMC NTS) 2018. In addition, the review team planned to assess the changes made since the Getting It Right First Time (GIRFT) review of orthopaedic surgery in 2015.
Training programme / learner group reviewed	Foundation surgery, CST and T&O surgery
Number of learners and educators from each training programme	The review team met with five foundation trainees, five CSTs and four higher T&O surgery trainees. The review team also met with clinical and educational supervisors and the following Trust representatives: • Director of Medical Education • Senior Medical Education Manager • PRUH Site Medical Education Manager • PRUH Site Deputy Medical Education Manager • Surgical College Tutor • Associate Director of Medical Education for Post Foundation • Educational Leads for T&O • Educational Lead for Urology.
Review summary and outcomes	Several areas of good practice were noted, including the effort that had been put into improving the level of operative experience available for T&O trainees following the recent significant changes, good working relationships within surgical teams and supportive educational and clinical supervision (see Good Practice section). One immediate mandatory requirement was issued: • The review team heard that there were at least two clinics which were run by unsupervised trainees; one in an isolated unit and one on-site. This practice should cease immediately. The review team also identified the following areas for improvement: • All trainee groups reported significant challenges with rota management including rotas being altered or rewritten at very short notice and difficulty in ensuring annual leave and study days were incorporated into the rota. • Departmental induction was inadequate for foundation trainees. The induction was described as brief and trainees received very little written information during or prior to their induction • Foundation trainees were supported by their supervisors but there was little departmental teaching and only variable, unscheduled and occasional access to clinics and theatre lists for training. Foundation trainees' workloads and ability to access learning opportunities would be positively

	impacted by the presence of non-medical colleagues such as physician associates or doctors' assistants, as well as rostered clinic and theatre time. • CSTs in T&O had not been allocated timetabled theatre sessions. In the week prior to the review, CSTs had been informed which theatre sessions and clinics they should attend for the following week and this had been well-received. Access to operative training for CSTs in general surgery was described as variable, depending on which firm the trainee was attached to • Placements for higher T&O trainees were not themed • The review team was concerned about the firm structure within the department and the impact of this on patient care, as well as trainees' workloads and access to learning opportunities • Higher trainees felt under pressure from Trust management to go to fracture clinic during on-call shifts, despite a heavy workload on the inpatient wards.

Quality Review Team			
HEE Review Lead	Dominic Nielsen Deputy Head of School London Postgraduate School of Surgery	**Head of Specialty School**	John Brecknell Head of School London Postgraduate School of Surgery
Deputy Postgraduate Dean	Anand Mehta Deputy Postgraduate Dean Health Education England (south London)	**Foundation School Representative**	Jan Welch Head of Foundation School, South London and KSS Health Education England
Lay Member	Jane Gregory Lay Representative	**HEE Representative**	Louise Brooker Learning Environment Quality Co-ordinator Health Education England (London)
Observer	Angela Fletcher Head of Postgraduate Medical and Dental Education Delivery Health Education Team Health Education England	**Observer**	Ed Praeger Deputy Quality, Patient Safety and Commissioning Manager Health Education England (London)

Educational overview and progress since last visit – summary of Trust presentation

The review team heard that recruitment had been a challenge for the Trust. There was a 16 whole time equivalent (WTE) rota including foundation year two (F2) trainees, core surgical trainees (CSTs) and junior clinical fellows (JCFs), which covered the Princess Royal University Hospital (PRUH) and Orpington sites. This rota had been introduced on 7 January 2019 and at the time of the review, 11 of these 16 posts were filled. The department had recruited four more JCFs who were due to be in post by April 2019. The Director of Medical Education (DME) explained that 20% protected time for education had been included in the JCF job plans to make the roles more attractive to candidates. It was hoped that the new rota would also offer improved training opportunities as it included 6 weeks at the Orpington Hospital site, where the majority of elective theatre lists

were run. The review team heard that there was ongoing work with the rota coordinator to include more theatre lists in the CST rotas and have locum staff or JCFs covering the wards where possible.

The middle-grade rota, which included trainees at specialty training level three and above (ST3+) also had 16 slots and covered the PRUH and Orpington sites during the day. The DME advised that there was a middle-grade doctor on-call overnight at the PRUH but that this doctor also covered the Orpington site.

The review lead asked whether the department had considered introducing non-medical staff into the team. The DME reported that advanced clinical practitioner (ACP) trainees had placements in the department and there was one surgical nurse assistant, but that the management team felt it was not appropriate to bring in new non-medical roles until the medical staffing levels were more stable.

Following the Getting It Right First Time (GIRFT) review in 2018, the trauma and orthopaedic surgery (T&O) service was to be redesigned. This included separation of elective and emergency surgery and more cross-site working for consultants. The DME reported that the plans were being finalised and job plans had been rewritten, but it was noted that Health Education England (HEE) and the School of Surgery had not been involved in this process. The DME advised that the redesign plans made training a priority and that the increased number of substantive consultants would stabilise rotas and improve trainee supervision. The Deputy Postgraduate Dean asked whether locum staff were paid differential rates across the Trust and was informed that they were not, but that this was a common misconception which made it more difficult to obtain ad hoc locum cover. The DME noted that in the general surgery team, morale had increased following recruitment and improved staffing levels.

The Clinical Lead reported that all trainees were taught how to submit exception reports but that the previous cohort had not been provided with access to the reporting system at their induction. This had been resolved and the current trainees were able to submit exception reports. The Clinical Lead advised that there had been a period of increased exception reporting among ST3+ trainees in autumn 2018 due to problems with the rota which meant that trainees were underpaid for several weeks. The trainees had been advised by the British Medical Association to exception report all additional hours worked during this time. The review team heard that the rota issue had been addressed.

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
TO1.1	**Patient safety** The core surgical trainees (CSTs) and specialty trainees at level three and above (ST3+) advised that multiple incident reports had been raised regarding the post-operative inpatient management of some trauma and orthopaedic surgery (T&O) patients. The review team heard that there were cases of patients developing hyponatraemia and acute kidney injury while on the surgical wards. The CSTs suggested that there was a lack of cover for the orthogeriatrics service and that the T&O and general surgery teams found it difficult to manage these patients, who often had complex needs. The CST and ST3+ trainees all felt that the ward cover and ward round arrangements contributed to these incidents, as the middle-grade rota did not allow for continuity of care. The ST3+ trainees advised that they were responsible for carrying out the ward round each day and that this could take until mid-afternoon due to the workload of reviewing a large number of complex patients they were not familiar with as well as answering bleeps and queries from colleagues. The review team was informed that each patient was seen by a consultant when they were first admitted and on the first day post-operatively, but that there was no consistent arrangement for ongoing consultant reviews. The trainees advised that some consultants did regular rounds of the patients they had admitted but that the main responsibility for daily rounds fell to the ST3+ trainee on-call. The CSTs reported that the department was trialling a new question proforma for ward rounds to prompt trainees to check for concerning signs and ensure that investigations such as blood tests were performed with appropriate frequency. The ST3+ trainees were aware of a new model where an associate specialist was rostered to take the first theatre case each day to release the consultant for inpatient ward rounds, but the trainees did not think this was happening in practice. The ST3+ trainees reported that they were under pressure to attend fracture clinic in the afternoons, despite the high workload on the inpatient wards and the need to oversee the junior trainees or junior clinical fellows (JCFs). The review team heard that there were often rota gaps in fracture clinic and that the clinics were often overbooked without consideration for staffing levels. The ST3+ trainees expressed concern that patients could wait up to three weeks for an appointment in fracture clinic and felt that this impacted negatively on the patient experience and affected treatment. This issue had been raised at the local faculty group (LFG) meeting but the trainees were unsure whether this was being addressed. A virtual fracture clinic was due to start at the end of March.	Yes, please see TO1.1 Yes, please see Other Actions
TO1.2	**Serious incidents and professional duty of candour** Trainees at all levels reported that they had been taught how to submit incident reports. Some trainees had submitted reports and had received feedback. The review team was informed that there were morbidity and mortality meetings in each subspecialty team which trainees were able to attend.	
TO1.3	**Appropriate level of clinical supervision** The foundation trainees felt well supervised when performing new tasks and stated that senior trainees and consultants were always available when they needed to ask questions or raise concerns. The foundation trainees described the consultants and other trainees as supportive.	

	The CSTs and ST3+ trainees advised that they usually had appropriate supervision and that clinics were usually reduced if the consultant was on leave, but that there were some clinics which were run by trainees without consultant supervision. The review team heard examples of one clinic at the Princess Royal University Hospital (PRUH) site and one off-site clinic which were regularly run without a consultant.	Yes, please see TO1.3
TO1.4	**Responsibilities for patient care appropriate for stage of education and training** The foundation trainees reported that they were not asked to undertake inappropriate tasks such as administering cytotoxic drugs, marking the operative site and taking consent for surgical procedures. The review team asked whether the trainees were required to perform non-clinical tasks such as portering. The foundation trainees explained that they sometimes chose to do these types of tasks to save time in clinically urgent situations but that they were not under pressure from colleagues to do this. However, the foundation trainees advised that having staff such as doctors' assistants on the wards to assist with simple medical and administrative tasks would impact positively on their workloads and reduce the need to work additional hours.	Yes, please see TO1.4
TO1.5	**Rotas** The review team heard that the department operated on a firm structure and that staffing levels and workloads varied between firms. Some teams did not have a foundation year one (F1) trainee which increased the workload for the F2 trainees. The foundation trainees worked day shifts within their firm. F1 trainees worked weekends but not night shifts. F2 trainees worked nights at the PRUH site covering the general surgery wards and the urology surgical patient admissions. All of the trainees expressed frustration with the administrative side of rota planning. The review team was informed of multiple instances where trainees had received new rotas at short notice, been moved between sites to cover rota gaps and had found that study days were not included in their rotas despite giving several weeks or months of notice. The process of booking annual leave and study leave was described as being very difficult. The ST3+ trainees felt that the rota planning system was unreliable and that they needed to separately inform the managers, department secretaries and clinic coordinators of their leave plans to ensure that they were not allocated to clinics on leave days. Some trainees advised that they had been instructed by managers to arrange clinic reductions with the department secretaries in order to take study leave on clinic days. The review lead asked what happened if leave was not scheduled into the clinic rota and the trainees reported that the managers had a list of JCFs who were more senior and would try to arrange for one of them to cover the clinic. Due to the firm structure within the department, foundation trainees and CSTs tended to have fixed on-call days, some of which clashed with departmental meetings or teaching sessions. The review team heard that this had been reported but not resolved. The CSTs reported that if they missed a learning opportunity such as an elective theatre list in order to cover a rota gap, they were not always able to access the same learning opportunity again. Access to theatre lists and clinic experience varied between firms. Some CSTs advised that they had regular, scheduled clinic time but others did not. The review team was informed that the T&O firm had sent trainees an email allocating clinics and theatre lists for the week of the review and that trainees had found it very useful. The CSTs reported that when they attended theatres the consultants were supportive and willing to train them. The ST3+ trainees noted that the new cross-site rota was not compliant with the junior doctor contract for the first three months, so trainees had been paid at a reduced rate	Yes, please see TO1.5a Yes, please see TO1.5b Yes, please see TO1.5c

	until this was resolved. In addition, trainees could be allocated to clinics at different sites on the same day, meaning that afternoon clinics sometimes started late if morning clinics overran or were overbooked. The ST3+ trainees were asked how rota gaps at CST level affected them and advised that there were occasions where there was no junior trainee or JCF on-call overnight so the ST3+ trainee had to hold both bleeps and cover both sets of duties. During the day, ST3+ trainees advised that consultants helped them by covering the theatre alone as far as possible, allowing the ST3+ trainee to remain on the inpatient wards.	
TO1.6	**Induction** All foundation trainees and CSTs had had inductions when they started in post. The foundation trainees had found their inductions too brief and felt that they were not adequately prepared for some aspects of the role such as their responsibilities on night shifts. Most foundation trainees had not received written information as part of their induction and advised that they would have found this helpful.	Yes, please see TO1.6
TO1.7	**Handover** The review team heard that there were handover meetings at 08:00 and 20:00 each day. The foundation trainees reported that the morning handovers were well-run and well-attended but that the evening handovers were sometimes unclear or less organised as they took place during the busiest period of the day for admissions. The trainees advised that despite this the consultants were always aware of the full patient list including outliers.	
TO1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The foundation trainees' level of access to theatre lists was varied, with those who were interested in becoming surgeons being encouraged to attend theatre more often than other trainees. The foundation trainees reported that access to theatres also depended on the workload and staffing within their firm, so some found it easier to arrange time away from the wards for learning opportunities and some felt unable to leave their wards without junior cover. Theatre lists were not scheduled into the foundation trainees' rotas. The CSTs also found that their firms impacted on the amount of time they spent in theatre, although they suggested that it would be beneficial if emergency theatres time was scheduled into their rotas. The ST3+ trainees found their time in theatre useful and felt that they were well-supervised and encouraged to gain operative experience. ST3+ trainees had opportunities to work in emergency theatres at the PRUH site and elective theatres at the Orpington site. The review team was informed that specialty trainees did not have themed placements so could work on several different subspecialty theatre lists over the course of a month, particularly at ST3 level. Trainees at ST6 and ST7 advised that they had worked with their supervisors to ensure that they were assigned to work on lists and in clinics which were more relevant to their subspecialty interests and training needs. The review lead enquired whether there was competition for learning opportunities between the trainees and non-training doctors. The CST and ST3+ trainees reported that, while non-training doctors had access to training opportunities and supervision, trainees were given priority for theatre lists as they had limited time to achieve	Yes, please see TO1.8a Yes, please see TO1.8b

	competencies and complete the operative numbers required by the curriculum. The ST3+ trainees were satisfied with their operative numbers and the supervision they received in theatre.	
TO1.9	**Protected time for learning and organised educational sessions** The trainees reported that they were usually able to attend the weekly departmental teaching session unless they were on-call that day or the previous night. Some trainees advised that they had missed teaching sessions because they had been unable to arrange for a colleague to hold the bleep. The foundation trainees found the teaching sessions run by other trainees and the sessions which focused on a particular subspecialty to be the most useful. The trainees were aware of an allocated time for weekly foundation and core teaching sessions but these teaching programmes were not running at the time of the review. The review team heard that the T&O team had started to hold weekly teaching where trainees presented clinical cases for discussion. Trainees were also able to attend the weekly trauma meeting which incorporated case discussions.	Yes, please see TO1.9
TO1.10	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** All foundation trainees had met with their educational supervisors (ESs) and advised that the ESs were proactive in ensuring they completed their portfolios and met their objectives.	

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.

TO2.1	**Impact of service design on learners** The foundation trainees and CSTs acknowledged that the firm structure within the department had some drawbacks but that it helped to foster good working relationships between colleagues in the same firm. All foundation trainees and CSTs felt valued by their teams, described the consultants and senior trainees as supportive and thought that the nursing and surgical teams worked well together. The CSTs noted it was also useful to be clinically supervised by the same small group of consultants for the majority of the time. However, the trainees agreed that the firm structure restricted access to clinic and theatres for trainees in certain subspecialties. The review team heard that the urology team worked under a 'consultant of the week' model, which	Yes, please see TO2.1

	offered improved continuity of care for patients and allowed trainees to work with different consultants. The ESs were asked about the firm structure and whether a consultant of the week model might work better across the department. The review team heard that the general surgery team had trialled this model in the past but that it had not worked well. The T&O consultants advised that as the team was understaffed and heavily reliant on locums, a consultant of the week model would not work. The ESs objected to this model as they felt that this would lead to long ward rounds by the end of the week and reduce continuity of supervision for trainees. The ESs advised that most consultants carried out daily ward rounds. The foundation trainees reported that they had less direct interaction with consultants so activities such as clerking patients and presenting to a senior trainee were very helpful. Clerking also allowed the foundation trainees exposure to a variety of patient cases. The ESs felt that Trust targets negatively impacted on training as consultants were under pressure to spend more time on service provision rather than teaching and to overbook theatre lists. The ESs advised that trainees often worked more slowly so it was not appropriate for them to be first operator on a full or overbooked list. The review lead asked whether the managers supported training and the ESs reported that the managers were pushed to ensure the department met its targets so were more concerned with the number of procedures performed than whether consultants provided good training. The ESs noted that the Trust received funding to support trainees and that, on average, patient outcomes were equally good when trainees were involved in their care. The ESs indicated that recruitment and retention of consultants had been a challenge for the department in recent years. The review team heard that the number of trauma patients seen by the Trust had increased following the closure of the emergency department at Queen Mary's Hospital in Sidcup. At the time of the review there were four substantive and four locum consultants in T&O surgery, with three new substantive consultants due to start work in early 2019.	

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.

	N/A	

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.

TO4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The ESs reported that they had programmed activities (PAs) in their job plans for supervision but that these were capped at 1PA. Some ESs felt that they needed to reduce clinical time in order to take on supervision responsibilities as their job plans were limited to 12PA in total. The ESs advised that although teams were meant to be integrated across sites, the T&O teams at the PRUH and King's College Hospital sites worked separately and had different staffing levels and operative numbers.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

TO5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The foundation trainees advised that they were able to complete workplace-based assessments with their supervisors. Some CSTs had experienced difficulty in getting consultants to complete assessment forms, particularly in theatre. Where possible, the CSTs reported that they asked senior trainees and JCFs to sign off assessments as they were more accessible. All foundation trainees and CSTs reported that they had had the opportunity to work on audits and quality improvement projects.	

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

	N/A	

Good Practice and Requirements

Good Practice
It was noted that the trauma and orthopaedic surgery (T&O) team had worked hard to improve the level of operative experience for trainees.
All trainees felt that their teams were supportive and that there were good working relationships between the surgical and nursing teams. The trainees reported that they had not experienced bullying or undermining within the clinical teams.
All foundation trainees recommended their posts and felt well supervised and valued by their clinical colleagues. The foundation trainees did not raise any 'red flag' indicators.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
TO1.3	The review team heard that there were at least two clinics which were run by unsupervised trainees; one in an isolated unit and one on-site.	This practice should cease immediately.	R1.2

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
TO1.1	The Trust must ensure that fracture clinics are organised to ensure appropriate staffing levels for the number of patients and that trainees are not required to attend fracture clinic as well as covering the inpatient wards.	Please provide both a plan for the structure of fracture clinics going forwards and evidence of trainee feedback to reflect that they are no longer required to cover fracture clinic when timetabled for other duties. This can take the form of trainee survey data or LFG minutes, please provide this evidence by 31 March 2019.	R1.7
TO1.5a	The Trust should ensure that trainees are given a minimum of eight weeks' notice for rotas and that pre-arranged study leave and annual leave days are included in rotas.	Please provide trainee feedback confirming that this is being done by 30 April 2019. This can take the form of trainee survey data or LFG minutes.	R1.12/ R3.12
TO1.5b	The Trust should ensure that CSTs in general surgery all have access to regular timetabled theatre sessions and that these sessions do not coincide with on-call commitments on a regular basis.	Please provide timetables confirming this along with trainee feedback from LFG minutes by 30 April 2019.	R1.15
TO1.5c	The department should continue to inform CSTs working in T&O of their clinic and theatre list allocations in advance.	Please provide trainee feedback confirming that this practice has continued by 31 March 2019. This can take the form of trainee survey data or LFG minutes.	R1.15

TO1.6	The department should seek feedback from the foundation trainees on how to improve the departmental induction and implement these changes for the next foundation trainee rotation.	Please provide trainee feedback following the April 2019 foundation trainee rotation.	R1.13
TO1.8a	Foundation trainees should have allocated time to attend relevant clinics and theatre lists included in their rotas.	Please provide copies of foundation trainee rotas including these allocations for the rotation commencing in April 2019.	R1.15
TO1.8b	The Trust should theme ST3+ T&O trainee placements so that trainees are able to practice procedures consistently and work through all areas of the curriculum in a structured way.	Please provide evidence that trainee placements are themed and mapped to the curriculum by 30 April 2019.	R1.12
TO1.9	The Trust should ensure that trainees do not miss teaching sessions due to on-call duties. Trainees who are on-call should be able to hand over their bleeps to attend protected teaching sessions.	Please provide trainee feedback showing that trainees are able to hand over their bleeps to attend teaching by 19 March 2019. This can take the form of trainee survey data or LFG minutes.	R1.16

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
TO1.4	The Trust is advised to investigate the options for increasing non-medical staffing in the extended surgical team. Recruitment is identified by all clinicians as a significant problem, but this route has not been used effectively so far.	The Trust is advised to investigate options such as advanced nurse practitioners, physicians associates and doctors assistants.	R1.7
TO2.1	The Trust is advised to move to a 'consultant of the week' model within the surgical teams in order to ensure regular inpatient ward rounds and allow trainees to work with different consultants.	The Trust is advised to look at the arrangements in teams such as urology which already follow this model and consider how this could be replicated in other teams.	R2.3

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The review team heard that there were systematic and ongoing patient safety risks relating to the management of T&O inpatients, in particular the lack of regular consultant review and the time taken for patients to be seen in fracture clinic following attendance in the accident and emergency department. These concerns will be reported to NHSI via the escalation of concerns protocol.	HEE

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Mr Dominic Nielsen
Date:	5 March 2019

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.