NHS
Health Education England

Bart's Health NHS Trust (Royal London Hospital)

General Surgery

Risk-based Review (on-site visit)

Quality Review report

05/02/2019

Final Report

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Quality Review details

Background to review	The Risk-based review was organised following the Education Leads Conversation (ELC) held on 14 August 2018, to discuss the General Medical Council (GMC) National Training Survey (NTS) 2018 results. During the meeting, it was noted that general surgery returned 11 red outliers and four pink outliers. The Trust acknowledged that there was a need for consolidating educational leadership in surgery at the Royal London Hospital (RLH) site and were keen for improvement. A Surgery away-day had been held. Local Faculty Groups (LFG) had been arranged for the Trust to gather feedback from the trainees and an Educational Lead for General Surgery had been appointed. It was realised that the workload was onerous for a single surgical tutor on the site and therefore a second Surgical Tutor was appointed. Overall, it was felt that the culture within the department also needed to be developed and support was required with job planning. The ELC concluded that despite the amount of internal work that was being undertaken, an external review of the department by HEE would be beneficial.
Training programme / learner group reviewed	General Surgery
Number of learners and educators from each training programme	The review team met with two cohorts of trainees, including six specialty trainees at grades four to eight (ST5-8) and two core surgery trainees (CSTs). The review team also met with a number of clinical and educational supervisors in general surgery and the following Trust representatives: • Director of Medical Education (DME), Rehan Khan • Medical Education Manager, Nicola Palmer • Clinical Director, Frances Hughes • Departmental Education Lead, Anna Minicozzi • Deputy Director Education Academy, Martyn Clark • RLH Surgical Tutors, Martin Griffiths and Nara Orban
Review summary and outcomes	The review team thanked the Trust for hosting and facilitating the review. The review team was pleased to hear that the following areas were working well: Excellent operative training was made available to core surgical trainees in general and vascular surgery. The development of new structures to support training in general surgery; specifically, the appointment of two new surgical tutors, the inception of a local faculty group (LFG) and a new induction package. The trauma service at RLH represented a valuable training resource for surgical trainees in London. However, the following areas were identified as of concern or in need of improvement:

The review team heard concerns about the lack of robust transfer of information arrangement for handover from the general surgical registrar on call overnight to the general surgical, vascular and trauma teams on duty the next day.

A new handover policy document was described which should be shared with HEE.

The review team heard that the general surgical registrar overnight covers vascular surgery and the trauma service as well as general surgical referrals, operations and inpatients. With vascular surgery designated a separate specialty since 2013, it was no longer appropriate for general surgical trainees to be working within a specialist vascular unit. The review team noted that that was only the case between 5:00pm and 8:00am in the weekdays

The review team recommended that the separation between general surgery and vascular surgery should be completed.

The conflict between an immediate responsibility as primary operating surgeon in theatre and as first attender at code-red trauma calls was highlighted. The review team was led to believe that an alternative individual was available to attend such trauma calls but their exact identity was unclear.

The Trust was asked to share the relevant escalation policy and work with the general surgical trainees to better define roles and responsibilities pertaining to their out of hours work.

The induction of new trainees was described as not being adequate in describing the structure of the department, defining roles and responsibilities and preparing them for requirements during out-of-hours work.

The department is required to put in place measures to ensure that trainees were not rostered to deliver out of hours service before an adequate departmental induction was completed.

The review team heard that the number of cases available for colorectal training at RLH was insufficient to support the current establishment of three trainees due to modest numbers served by the department and many of these being diverted to a trial of robotic surgery and to non-training grade fellows.

The review team requested that the trust work with HEE in determining the appropriate number, seniority and special interest of trainees in the department.

The review team found no evidence that exception reports were being actively discouraged but with none received and with clear and ongoing workload / training issues, more needed to be done to encourage these valuable items of real-time feedback.

Discussion of workload and exception reporting should form an integral part of the LFG meetings.

The review team recognised the new LFG was a welcome addition which required further development. Thought should be given to making these accessible for any trainee with an issue to attend and escalate concerns without risk. It was of interest that the core trainees seemed to be unaware of the existence of a separate LFG for core surgical training.

The review team found that the allocation of educational supervisors (ES) to general surgical trainees appeared to be ad-hoc.

The DME's team is required to support the Surgical Tutors in assigning appropriately trained ESs to trainees and matching job planned time to the ESs who did the valuable work.

The review team encouraged the department to establish robust links with their human resource department to ensure that they received real time notification of trainee allocation by HEE. This process would allow the

	trainees to receive their contracts and work schedules as per expectation of NHSE/I. The issues discussed with the various trainee groups met by the review team were complex and in many cases the conversations merely scratched the surface due to limitation of time. Based on the results of the 2019 GMC national training survey, HEE will review the need for a trainee focus group later in 2019.

Quality Review Team			
HEE Review Lead	Mr John Brecknell Head of the London School of Surgery	**External Clinician**	Mr Chetan Bhan Consultant Colorectal Surgeon Training Programme Director
Deputy Postgraduate Dean	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England for North London	**HEE Representative**	Andrea Dewhurst Quality, Patient Safety & Commissioning Manager Health Education England (London)
HEE Representative	Tolu Oni Learning Environment Quality Coordinator Quality, Patient Safety and Commissioning Team Health Education England (London)	**Lay Member**	Jane Gregory Lay Representative

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

The review team thanked the Trust for accommodating the review and for the efforts made in facilitating the process.

The review lead outlined the concerns raised by the 2018 General Medical Council (GMC) National Training Survey (NTS) returns and acknowledged the responses from the Bart's Health Education Academy (EA) team which detailed the current departmental structure for general surgery and the strategic direction taken by the Trust to improve training and services.

A Surgical Tutor (ST) and Clinical Director (CD) reported that the bulk of elective and emergency acute services offered, namely colorectal, hepatobiliary (HPB), upper gastrointestinal (UGI), vascular and trauma services made by the general surgery department was very busy. The review team heard that the trauma unit was run separately and that a significant number of surgical operations within the unit were complex. The (CD) noted that that the limited general surgical operating opportunities may have contributed to the poor feedback from the 2018 GMC NTS returns.

The review team heard that following an internal recognition of the workload intensity, a second Specialist Registrar (SpR) had been added to the rota between 14:00 and 22:00 to improve the workload out of hours (on-call) for trainees within the general surgery department. The review team also heard of the introduction of a second junior tier doctor to provide extra support. The review team was informed that an on-site consultant presence was always maintained for trauma operating and for the resuscitation of 'code red' and 'black' trauma calls. This was confirmed by a ST who asserted that all procedures undertaken were always with adequate consultant supervision. A ST informed the review team of a new rota arrangement in which vascular surgery had

separate on-call rotas for its registrars covering day time and weekends. The CD indicated that the new rota arrangement had made a significant difference to workload and had improved patient care within the department.

The review team heard of the inception of a Local Faculty Group (LFG) within the department, based on what were felt to be successful Foundation and core surgical RLH LFGs. The Educational Lead (EL) reported that the first LFG took place in January 2019 and subsequent meetings would be held on monthly basis to encourage high attendance and to promptly address concerns raised. The review team heard that there was a higher surgical trainee representative invited to attend the LFG and part of their responsibility would be to report concerns from the wider general surgical trainee body.

The Director of Medical Education (DME) indicated that the use of trainee representatives in information gathering had contributed significantly to the substantial amount of feedback received from the first LFG session. However, there was an acknowledgement that several trainees were unaware of the terms of LFG.
When asked about whether trainees were introduced to the Freedom to Speak Up Guardian, the Medical Education Manager responded that all trainees were signposted as per information embedded within their induction package.

The DME informed the review team that the department had appointed a two new individuals to replace the outgoing Surgical Tutor, whose role was to act as college liaison and subject matter expert (SME) around the implementation of widespread curricula changes within the Trust. The review team heard that the roles of the two STs would be to chair the monthly LFG meetings, supporting all surgical supervisors to carryout exception reports (ERs) and implementing bespoke induction for surgical trainees. The DME also reported that the STs would be involved in a three-yearly educational appraisal exercise for the supervisors. The review team were told that a surgical education programme had been put in place by the departmental education lead on Friday mornings in response to feedback from the first LFG and that attendance was increasing.

In regard to an overarching strategy, the review team heard that Bart's Health NHS Trust was reconfiguring surgical services. In order to optimise learning opportunities for surgical trainees based at the RLH, the DME asked about the feasibility of split-site trainee allocation. Strengths and challenges of such a model were discussed.

When asked about why there were not any exception reports (ERs) submitted other than at Foundation level, it was suggested that this was a widespread cultural issue across all the specialties within the Trust; however, the review team noted that the Trust was exploring appropriate solutions. It was suggested that the LFG forum could be used as an outlet to discuss working lives and therefore improve the level of ERs raised at the RLH site. Despite only having one appointed Guardian of Safe Working Hours (GoSWH) serving all sites across Bart's Health NHS Trust, the DME reported that plans were underway to proactively engage trainees with the Trust's GoSWH. The review team acknowledged that the issues around ERs were complex but not limited to the RLH site.

The review team heard of the work undertaken by the department to foster a 'safe space' for learning from Serious Incidents (SIs). The CD reported that trainees were always given opportunities to present cases around surgical SIs that were relevant to training.

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
GS1.1	**Patient safety** The review team heard that the arrangement for handover from the general surgical registrar on call overnight to the general surgical, vascular and trauma teams on duty the next day was an area of potential patient safety risk due to lack of a robust system for safe transfer of information. The review team were not made aware of any specific episodes where patient safety had been compromised by this, but only because of work behind the scenes by vascular and trauma junior medical teams finding patients, and manually maintaining patient lists. Further areas of potential risks to patient safety identified included the general surgical registrar overnight covering vascular surgery and the trauma service as well as general surgical referrals, operations and inpatients. With vascular surgery designated a separate specialty since 2013, it was no longer appropriate for general surgical trainees to be working within a specialist vascular unit. The review team noted that that was only the case between 5:00pm and 8:00 am in the weekdays. The conflict between an immediate responsibility as primary operating surgeon in theatre and as first attender at code-red trauma calls was highlighted. The review team was led to believe that an alternative individual was available to attend such trauma calls, but their exact identity was unclear. The review team heard that trainees would recommend the trauma and general surgery services offered at the Trust to their friends and families.	Yes, please see GS1.1a Yes, please see GS1.1b Yes, please see GS1.1c
GS1.2	**Serious incidents and professional duty of candour** The core surgical trainees (CSTs) found that attending the vascular monthly meetings where Serious Incidents (SI) were discussed to be supportive and the CSTs appreciated the learning and clinical governance perspective that it provided. The review team heard that the CSTs were not aware of any bi-monthly Trust newsletter around SIs. The Clinical Director (CD) reported that the department encouraged trainees to report and be involved in the learning around Sis.	
GS1.3	**Appropriate level of clinical supervision** The review team was informed that there was always consultant presence when required and that clinical supervision was appropriate.	

	The core trainees reported that the level of clinical support received from their trainer during minor surgical operations was very helpful. The review team was made aware that general surgical trainees were responsible for the primary survey in adult trauma calls. However, the trauma team leader (usually consultant) provided support and oversight from the emergency department.	
GS1.4	**Rotas** The review team heard that trainees' rota arrangements were based on a sixteen-week rotation. The review team heard of recent changes to the provision of an out of hours and emergency service across the general surgery, trauma and vascular surgery services. Information provided by the leadership team is described above. In addition the review team learnt that the junior medical tier (of 16 staffed) had only one vacancy at the time of the visit but that current registrar level staffing was not adequate to provide for the delivery of the second, (2-10 pm) duty middle grade doctor.	
GS1.5	**Induction** It was noted that all trainees had received a corporate induction on their first day, although the occupational health (OH) and hospital information technology (IT) components were described as inefficient. The supervisors reported that an appointed staff grade doctor had undertaken work to improve the formal departmental induction process for vascular surgical trainees and plans were underway to improve the trauma unit departmental induction. The review team also heard that trainees were allocated time in an afternoon to complete their electronic learning modules. The CSTs reported that their departmental induction was usually delayed until the third day on the job, by which time, they had already been allocated to emergency duties.	Yes, please see GS1.5
GS1.6	**Handover** The review team heard that trainees perceived handover meetings to be disorganised. The handover meeting was usually attended by general surgery consultants with no consistent senior representation from the vascular or trauma teams. The CD acknowledged that there were deficiencies at the morning handover and mentioned work, recently completed to improve the morning handover. The CD advised the review team that trauma and vascular patients were handed over at the end of the morning handover process; this was understood to be electronically/verbally communicated to representatives from the trauma and vascular teams. The review team was made aware that no vascular handover meetings took place in the morning. Trainees reported having a trauma multidisciplinary team (MDT) meeting, between 8:00am and 9:00am. In practice, the trainees reported arrangements for transfer to the vascular and trauma teams being ad-hoc with teams often not represented at the meetings and patients being identified directly by the respective junior medical teams and recorded on manually compiled patient lists.	Yes, please see GS1.1a

GS1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team was informed that the RLH offered training opportunities in the area of functional proctology which were not represented in the curriculum. It was understood by the review team that the trauma case load reduced capacity for elective operating. The review team heard that the Core Surgical Trainees (CSTs) enjoyed an array of training opportunities. The review team noted that CSTs had access to up to three whole day operating lists in an average week, with training appropriate to their learning needs. The review team also learned that the last few months had been clinically fulfilling for CSTs and that the trainees were making rapid progress against their curriculum. The review team heard that the trauma service at the RLH represented a valuable training resource for surgical trainees in London. Approval as a site for the training interface group fellowship in major trauma had recently been awarded, supported by HEE. The presence of the new fellow had altered the experience of trauma for other trainees somewhat, with a shift towards trauma call attendance and away from decision making and operative management at the heart of the trauma team. The team heard about the trauma surgeon of the week model and the availability of an in house definitive trauma skills course.	Yes, please see GS1.7
GS1.8	**Protected time for learning and organised educational sessions** The review team heard that the trainees were usually able to attend their regional teaching.	
GS1.9	**Adequate time and resources to complete assessments required by the curriculum** The Clinical Supervisors (CSs) informed the review team that trainees were assigned to consultants for a period (between six to twelve months) and that they believed the trainees benefited from rotation across consultants with different expertise. The review team heard that trainees achieved low operative numbers and that this was recorded at the Annual Record of Competency Progression (ARCP). It was understood by the review team that the CD met with each trainee to discuss areas that could be improved and to support each trainee in achieving their indicative operative numbers.	

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.

GS2.1	**Impact of service design on learners** The review team heard that trainees were encouraged to raise exception reports (ERs) when they worked late. It was understood by the review team that most trainees were aware of who the Guardian of Safe Working Hours (GoSWH) was. The review team learnt that the GoSWH was present at Trust induction. The review team heard that trainees were reported to have been provided with the login credentials required to submit ERs and that the department never discouraged trainees from raising ERs. The ESs and CSs indicated that they were aware that trainees often worked longer hours, which was taken as time in lieu. However, the review team heard that the low level of ERs raised in the department was felt by trainees, in part, to be linked to the bureaucratic nature of ER systems.	Yes, please see GS2.1
GS2.2	**Appropriate system for raising concerns about education and training within the organisation** The review team was pleased to learn about the inception of a monthly local faculty group (LFG). The review team noted that no core trainees attended the first LFG held in January 2019 and that the core trainees were unaware of a separate Core Surgical Trainee (CST) LFG. It was also reported by the specialty trainees that the process was very new.	Yes, please see GS2.2
GS2.3	**Organisation to ensure time in trainers' job plans** The review team was informed that the allocation of educational professional activities in the job planning of consultants did not robustly represent their responsibility as education and clinical supervisors. Further, the team heard that the allocation of trainees to supervisors was somewhat ad-hoc and determined by trainee request and supervisor capacity. The review team also heard that the clinical director and other members of the department's staff received notification of trainee allocation from HEE much later than the agreed 12 weeks' notice given to the Trust through the Trainee Information Systems This represented a challenge in the assurance of complete departmental staffing.	Yes, please see GS2.3a Yes, please see GS2.3b
GS2.4	**Systems to manage learners' progression** The review team heard that opportunities for operative training were limited in colorectal surgery and it was felt that there were not enough cancer cases to meet the training needs of 3x colorectal surgical trainees. It is in this curricular area where the acquisition of indicative numbers is most critical. Other areas of operative practice, notably in functional proctology, provided training opportunities outside the curriculum, and there was a well-developed inflammatory bowel disease MDT and resection programme delivered by the UGI team and not accessible to colorectal trainees. The department treated about hundred patients with colorectal malignancy surgically per annum, of which 40 were anterior resections. Many of these cases were treated in a local pilot of robotic assisted surgery and others were assigned to non-training grade doctors. The review team acknowledged that a good colorectal training year for a senior trainee should have 20-30 anterior resections and that the general surgical department at RLH therefore fell a long way short of what was required. Thoughts about cross site training as part of new Barts Health Surgical Strategy, described by the leadership team and reported above may form part of a solution here. Colorectal trainee allocation to operating lists was inadequate at 1 to 2 per month. One senior trainee had added only 22 cases in a year to their logbook. A balance was described between a valued exposure to major trauma management and a loss of progress against indicative numbers. While a six-month placement might be enough to gain sufficient exposure to trauma, it was not long enough to fully embed within and become a trusted member of the team.	Yes, please see GS2.4

	The review team heard that the tension between doctors in training and trust appointed doctors had impacted upon the colorectal department and the number of cases available to trainees. It was understood by the review team that the department had taken steps to manage this tension through improved on-call rota coordination. Operative training for trainees in other areas of general surgery was at least acceptable.	

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.

GS3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The review team were specifically told that trainees were unaware of any culture of bullying and undermining (B&U) behaviour. However, the review team heard in passing of an instance where a trainee felt that they had been reprimanded in front of their colleagues and of an instance where a trainee had received emails which they felt were undermining in nature. When asked by the review team about the processes for trainees to raise their concerns around B&U, the CD responded that there were posters around the hospitals and that trainees were also signposted to report cases of B&U to the Freedom to Speak Up Guardian.	
GS3.2	**Access to study leave** The review team heard that while there were some restrictions on trainee access to leave, it was possible to overcome these with perseverance.	

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.

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.

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.

Good Practice and Requirements

Good Practice
• The review team was pleased to hear that excellent operative training was made available to core surgical trainees in general and vascular surgery. • The review team was pleased to learn about the development of new structures to support training in general surgery; specifically, the appointment of two new surgical tutors, a surgical education lead, the inception of a local faculty group (LFG) and a new departmental induction package. • The trauma service at RLH represents a valuable training resource for surgical trainees in London.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	No immediate Mandatory Requirements	n/a	

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
GS1.1a	The review team heard about the arrangement for handover from the general surgical registrar on call overnight to the general surgical, vascular and trauma teams on duty the next day. There was doubt about the robustness of safe information transfer to trauma and vascular teams. A new policy document was described.	The Trust is required to share the new Handover policy, to demonstrate the safe and auditable handover of information from the overnight general surgical team to the vascular and trauma teams. The effectiveness of Handovers should be a quality monitoring standing item in the monthly LFG and minutes should be sent to HEE for the next 2 meetings. Please provide initial updates by 31 May 2019.	R1.14
GS1.1b	With vascular surgery a separate specialty since 2013, it is no longer appropriate for general surgical trainees to be providing middle grade cover within a specialist vascular unit. We note that that is now only the case between 5:00pm and 8:00am in the weekdays but recommend that the separation is completed.	The Trust is required to report on a schedule of separation of the vascular and general surgical emergency rosters to be completed within 12 weeks. Please provide initial updates by 31 May 2019.	R1.7
GS1.1c	The conflict between an immediate responsibility as primary operating surgeon in theatre and as first attender at code-red trauma calls was highlighted. The review team was led to believe that an alternative individual was available to attend such trauma calls, but their exact identity was unclear.	The Trust is required to share the relevant escalation policy with HEE, including the clear delineation of the point of contact for code-red trauma calls when then general surgical registrar is engaged by the emergency theatre. The Trust is required jointly with the general surgical trainees to clearly define roles and responsibilities pertaining to their out of hours work and provide documentary evidence that this is complete. Please provide initial updates by 31 May 2019.	R1.12
GS1.5	Some trainees are rostered to provide out-of-hours work before being able to complete a comprehensive departmental induction and understand their roles and responsibilities.	The department is required to review and implement an induction which is fit-for-purpose and ensure that no trainee is rostered to deliver out of hours service before their departmental induction is completed. The Trust is required to send the departmental induction pack to HEE and confirm attendance at departmental induction for all trainees before they are rostered for out-of-hours work. Please provide initial updates by end of 31 May 2019.	R1.9

GS2.1	The review team found no evidence that exception reports were being actively discouraged but with none received and with clear and ongoing workload / training issues, more needs to be done to encourage these valuable items of real-time feedback.	The Trust is required to include exception reporting data as a standing item in LFG and monitor this against reported workload. The Trust should undertake improvement work with the GoSWH to enhance working lives through reporting rates amongst trainees in general surgery, vascular surgery and trauma at RLH. Please provide initial updates by end of 31 May 2019.	R2.1
GS2.2	The review team recognised the new LFG as a welcome addition which required further development. Thought should be given to making it accessible for any trainee with an issue to attend and escalate concerns without risk. It was of interest that the core trainees seemed to be unaware of the existence of a separate LFG for core surgical training.	The Trust is required to provide minutes of both the newly introduced general surgery Local Faculty Group (LFG) and existing core surgery LFG to demonstrate improved trainee attendance. Please clarify to the core surgical trainees in both general and vascular surgery which LFG they should attend. Please provide initial updates by end of 31 May 2019.	R2.7
GS2.3a	The departmental allocation of Education supervisors was described as ad-hoc depending on trainee choice and trainer availability.	The department educational lead is required to formalise the allocation of Education Supervisors to trainees and provide this information at the time of trainee allocation. The DME's team is required to quality assure the appointment, appraisal and appropriate SPA allocation in job plans for all educational and clinical supervisors in the department. The DME's team is required to report on arrangements made and provide an update on educational appraisals and the implementation of the Trust's job planning framework as it pertains to the allocation of SPAs for education in the department. Please provide an update by 31 May 2019.	R2.10
GS2.4	The review team heard that the number of cases available for colorectal training at RLH was insufficient to support the current establishment of three trainees.	The departmental education lead and Surgical Tutors are required to work with HEE Specialty School in determining the appropriate number, seniority and special interest of trainees in the department. Once agreed this should be implemented by October 2019. Please provide initial updates by 31 May 2019.	R1.15

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**

GS2.3b	The department are encouraged to establish robust links with HR to ensure that they receive notification of trainee allocation by HEE within the agreed time-lines.	Please provide information of data received and compliance with the NHSE/I expectations regarding the delivery of contracts and work schedules to trainees. Updates to be sent to HEE by 31 May 2019	R2.20
GS1.7	The department provides highly valued experience in Trauma for surgical trainees. Please consider ways of maintaining the availability of a genuine trauma experience to vascular and general surgery trainees at RLH, alongside the delivery of excellent training to the new major trauma TIG fellow.	The Trauma training experience should be included in the curricula section of the standing LFG discussion items. Please provide evidence through LFG minutes. Initial updates to be sent to HEE by 31 May 2019.	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE to host a conversation to review the post establishment in general surgery at RLH to include in its scope: • The current numbers of colorectal resection cases made available for training at RLH • Clinical activity and training capacity on other BH sites • The balance of seniority and special interest of general surgical specialty trainees allocated to RLH • Trainee allocation from the vascular surgery programme	London HoS Surgery, NCEL TPD for general surgery, HET, QPSC
HEE to analyse the GMC NTS 2019 results and review the need for a general surgery specialty trainee focus group later in 2019	London HoS Surgery, DPGD, QPSC

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Mr John Brecknell
Date:	11 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.