

# Bart's Health NHS Trust (Newham University Hospital)

Surgery

Risk-based Review (on-site visit)



## Quality Review report

26 February 2019

Final Report

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## Quality Review details

<b>Background to review</b>	<p>The Risk-based Review (on-site visit) was organised following the Risk-based Review (Educational Lead Conversation) to discuss the progress against the concerns raised in the General Medical Council National Training Survey (GMC NTS) 2018 results.</p> <p>During the ELC, a number of concerns were discussed. These included induction, supervision, learning environment, handover and escalation amongst other cultural issues with junior-senior interactions and working relationship with Trust appointed middle grade doctors.</p> <p>Following the ELC, the Trust advised that they would undertake an internal review of surgery (after considering the Royal London Hospital model) and would welcome HEE support and/or a quality intervention to help bring around the changes required.</p>
<b>Training programme / learner group reviewed</b>	<p>Surgery</p>
<b>Number of learners and educators from each training programme</b>	<p>The review team met with six F1 and F2 doctors in Urology, General Surgery and Trauma &amp; Orthopaedics (T&amp;O). It was disappointing that the trust was unable to facilitate a meeting with any of the higher trainees in T&amp;O. A subsequent meeting will be arranged shortly to review the training for that group in light of the GMC survey results (2018).</p> <p>The review team also met with surgery clinical and educational supervisors and feedback was given to the members of the including:</p> <ul style="list-style-type: none"> <li>• Chief Medical Officer, Alistair Chesser</li> <li>• Managing Director of Education Academy, Lois Whittaker</li> <li>• Associate Director of Quality, Stacey Forde</li> <li>• Director of Medical Education, Emma Young</li> <li>• Medical Director, Sara Lightowlers</li> <li>• Deputy Director of Medical Education, Helen Parker</li> <li>• Deputy Director Education and Quality (Medical &amp; Dental), Martyn Clark</li> <li>• Deputy Managing Director, Deborah Madden</li> <li>• Medical Education Development Manager, Nate Hill</li> </ul>
<b>Review summary and outcomes</b>	<p>The review team thanked the Trust for hosting and facilitating the review.</p> <p>The review team was pleased to hear that the following areas were working well:</p> <ul style="list-style-type: none"> <li>• The review team was pleased to hear that there was a rich spectrum of clinical case-mix and a good educational environment for curriculum relevant learning for foundation trainees in Urology and T&amp;O.</li> <li>• Specific interventions including dedicated senior-led teaching sessions, access to operating theatre and clinics in T&amp;O as well as Urology were greatly appreciated by foundation trainees.</li> </ul>

- The review team commended the Trust on supporting trainees to undertake audits and quality improvement.

However, the following areas were identified as of concern or in need of improvement:

- **Supervision** - The review team heard that foundation trainees in general surgery often felt unsure of how to escalate concerns with deteriorating in-patients, unclear about their senior surgical supervision out-of-hours, and therefore anxious and unsafe working in the clinical environment. There appeared to be a culture of reluctance to raise concerns to Consultants until a crisis point had often been reached or passed, with the possibility of an adverse outcome for patients. The issue seemed to be exacerbated by the lack of clarity of which consultant was responsible for the patients on list, shared on call with locum emergency surgeons and no consultant-of-the-week structure. The review team heard of foundation doctors struggling to find help from other specialties at weekends with undue delays in responding to requests for input.
- **Handover** - There was perceived lack of a robust handover meeting (at 8am and 8pm weekdays and 3pm on Fridays). The review team found that there was poor cross-over arrangement for out of hours shifts, which was linked to an ineffective handover meeting. Trainees providing cross-cover to General Surgery did not receive a regular handover of patients required to be reviewed. This left foundation trainees feeling vulnerable and often unaware of any potential patients at risk of deterioration.
- **Consultant ward rounds** - The review team heard that the general surgery consultants had been allocated time in their job plans to undertake daily ward rounds but found no evidence of regular, predictable structured consultant led ward rounds. The trainees described a culture of 'ad-hoc' consultant ward rounds occurring from four times a day to once a week, often repeating rounds already completed by middle-grade doctors. Not all patients were reviewed on consultant ward rounds and often the decision about 'who should be seen' was left to the most inexperienced member of staff.
- **Workload** - The workload appeared to be variable between firms. Although the foundation doctors were supportive of each other and willing to share the work-load, there was little evidence of attempt to manage or monitor workload or a system to cross-cover for absences.
- **Teaching** – There was no evidence of any consultant delivered ward-based teaching or completion of any supervised learning events. The review team was made aware that local Monday (8am -9am) morning teaching sessions lacked a curriculum, consultant oversight and that the delivery of teaching was unstructured and delivered by peers, with little impact on learning.
- **Induction** - The review team heard that the general surgery departmental induction was perceived by trainees not to be fit for purpose and usually comprised of an informal chat combined with a large (approx. 100-page) document of protocols/ procedures. The trainees were not prepared for the working pattern, departmental structure, time-table, learning opportunities, PDPs, escalation nor encouraged to consider exposure to operating theatres for aspiring surgeons.
- **Workplace culture** - The review team was disappointed to hear about a low-level but frequently witnessed/ experienced culture of tolerating bullying & undermining from consultants in the general surgery department. The review team recognised that individual trainees affected by this behaviour had access to pastoral support from their educational supervisors, however it found no evidence to suggest that there was a level of departmental ownership or willingness to change, when addressing these issues.
- **Clinical governance** - The review team heard that access to Mortality and Morbidity (M&M) meetings were often disrupted due to frequent

cancellations. The trainee's perceived the choice of cases discussed at these meetings to be ad-hoc and lacking coherence with clinical challenges /concerns and minimum effort appeared to have been made to share any 'lessons learnt'.

### Quality Review Team

<b>HEE Review Lead</b>	Dr Indranil Chakravorty Deputy Postgraduate Dean, North East London	<b>External Clinician</b>	Mr Dominic Nielsen Deputy Head of School of Surgery Health Education England
<b>Foundation Representative</b>	Dr Keren Davies Director NCEL Foundation School	<b>Lay Member</b>	Robert Hawker Lay Representative
<b>Observer</b>	Andrea Dewhurst Quality, Patient Safety and Commissioning Manager Health Education England	<b>HEE Representative</b>	Tolu Oni Learning Environment Quality Coordinator Quality, Patient Safety and Commissioning Team Health Education England

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

The Director of Medical Education (DME) and Divisional Director for Surgery and Cancer (DDSC) gave an update of the progress made since the 2018 GMC NTS results and outlined the current issues experienced within the general surgery department.

The DME reported that the Trauma & Orthopaedic department (T&O) offered training to foundation level and higher (Specialty Training Level 3 and above) trainees. The DME indicated that the services offered within T&O mainly focused on the training and educational needs for its higher trainees. The Education Lead (EL) for T&O indicated that the department had taken on board negative feedback regarding teaching, training and out of hours supervision from the 2018 GMC NTS results. The DME confirmed the positive improvements made by the department in ensuring that trainees at every level had access to curricular relevant training. The staffing levels within T&O had been supplemented with the addition of two senior doctors who provided elective orthopaedic surgery and that efforts were made by the department to ensure all trainees in T&O had access to regular teaching sessions.

To support this, the review team heard that based on the discussions held with trainees in December 2018 the T&O department had:

- Consolidated a formal senior -led handover process at night
- held daily consultant-led trauma meetings that included regular teaching / CPD
- set up a weekly orthopaedic teaching sessions specifically for foundation trainees
- monitored feedback received on the quality of teaching sessions

In contrast, the review team learned that in spite of the significant efforts made by the EA to mirror progress achieved in T&O: the reduced staffing level within the general surgery department made it challenging to maintain on-going teaching and learning arrangements. The DME reassured the review team, that plans were underway to establish regular weekly teaching sessions.

The review team heard of the divisional strategy for general surgery, Urology and T&O across Bart's Health NHS Trust (BHNT). The DDSC reported that a review of all surgical services across BHNT had been carried out and that the release of results was expected in April 2019. It was understood by the review team that BHNT would be consolidated into one surgical network with (Newham University Hospital) NUH focussing on elective/

ambulatory services and all acute/ emergency cases would be directed to the Royal London Hospital (RLH) and Whipps Cross University Hospital (WXUH). The DDSC also suggested that the bulk of elective and emergency trauma cases, and fragility fractures would be remitted to WXUH.

In terms of the Getting It Right First Time (GIRFT) initiative: the DME reported that arrangements were in place with the Training Programme Director (TPD) for Orthopaedics to combine the trainee placements so that trainees from RLH and NUH had shared experience in trauma and elective training, respectively

The DME reported that cross-cover during on-call (at night) was provided by the T&O / Urology / General Surgery foundation trainees. The review team also noted that cross-cover was an area of concern for trainees, that the Trust was aware of these issues and the resultant impact it had on emergency consultant cover within the department.

The review team heard that the difficulty in maintaining adequate staffing at middle grade level was compounded by the complex recruitment pathway for candidates requiring visas. The DDSC acknowledged the difficulty in recruiting and retaining staff at middle grade level which was now supplemented by locum emergency consultants (x2). The DDSC asserted that, working with new locum registrars and consultants who were often without previous United Kingdom (UK) experience and were not acquainted with the department maybe challenging. The locum middle-grade doctors were not able to contribute to the training and educational needs of foundation trainees. It was understood that substantive recruitment plans were underway to fill the roles of Clinical Lead (CL) and Clinical Director (CD).

The DME updated the review team on the alternative non-medical workforce plan that the Trust had put in place to address rota gaps in the department. The review team learned that BHNT was part of the Physician Associate (PA) programmes in Queen Marys University of London (QMUL) and that it had appointed a PA lead as part of its future workforce plan for non-medical staffing. The review team also heard that NUH had an established Nurse Practitioners (NPs) body and that efforts were underway to explore avenues of integrating them into the departmental rota.

The review team heard that the department held local faculty group meetings with engagement from general surgeons and the education team. The DDSC informed the review team that the action plan from the governance meetings was set out to ensure senior leadership presence at the daily post-take ward round. To support this, the DME also confirmed that a new emergency surgery team had been introduced into the department, which comprised of two long-term locum consultants, who provided daily clinical reviews of acute admissions between 8am-5pm.

When asked about the escalation pathway at ward rounds and handover: the review team heard the action plan would ensure that higher trainees and middle grade doctors were fixed for the week of emergency surgery to ensure continuity of care for patients that needed to be seen.

The review team noted that the department had access to documentation that outlined the escalation pathway plan for reporting Serious Incidents (SIs).

The EL for Urology reported that the absence of emergency urology consultant during on-call (at night), meant that all urological emergencies had to be transferred to RLH. The review team heard that NUH had a well-established link between its general surgical senior doctors on site and the RLH on-call senior doctors so that clinical advice pertaining to urological emergencies that were not transferable was sought over the telephone. The review team heard that there were ad-hoc plans in place to ensure middle grade doctors were adequately supported during the process of patient admission.

The review team noted that substantive consultants in general surgery department were appointed as Educational Supervisors (ESs). The DME reported that all ESs in the department participated in the formal appraisal programme and that their job plans were regularly reviewed to include time for supervision and teaching.

The review team heard that the department held robust Mortality and Morbidity (M&M) meetings. The DDSC reported that patient deaths and concerns that related to failure in care were always discussed at the M&M meetings and escalated to the Medical Director (MD) at the SIs complaints review meetings. The review team noted that the SIs investigative processes were reported to be transparent and that attendance at M&M meetings was encouraged from all staffing levels.

The review team learned that there were very few incidents raised by the foundation year trainees. The DME reported that the Trust was committed to improving this and that plans were underway to empower trainees to report issues related to patient safety. The EL for T&O informed the review team that recent enhancement in the

team structure had raised trainee awareness on how to promptly escalate concerns. The DME indicated that trainees received written responses in their Trust emails each time they raised an electronic incident (Datix) report. The review team heard that the department had mechanisms in place that ensured learning was obtained from SIs and that the Trust had embedded an interactive (WhatsApp) communication system so that lessons from SIs were cascaded widely across the BHNT sites.

At the time of visit, the DME confirmed that as “next step strategy” the Trust intended to implement a new surgical training model at foundation year level. The review team heard of the on-going effort made by the Trust in mirroring the Queen’s Hospital model for foundation surgical training. The DME emphasised that the possibilities were immense and that there were good patient case mix to provide trainees with the opportunity to expand their knowledge and training.

The review lead also encouraged the Trust to seek advice from Health Education England about exploring other sustainable developmental plans for surgical training at foundation year level.

## 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
S1.1	<p><b>Patient safety</b></p> <p>The review team found that the absence of adequate middle-grade covers in the department had made it difficult for trainees working out-of-hours to understand and negotiate effective escalation pathways when managing deteriorating patients. The Divisional Director for Surgery and Cancer (DDSC) indicated that the difficulty in escalation was often compounded by the absence of adequate middle-grade cover in the department.</p> <p>The foundation year trainees reported that the escalation pathway for raising patient safety concerns in the department lacked clarity. The review team felt that there appeared to be a culture of reluctance to raise concerns to consultants until a crisis</p>	Yes, please see S1.1

	<p>point had been reached which resulted in the possibility of an adverse outcome for patients.</p> <p>The DDSC acknowledged that patients were occasionally missed from handover lists. Trainees reported that timely consultant review of deteriorating patients was often absent in the department, with an occasional patient anecdotally missed on consultant rounds for more than two weeks. The issue seemed to be exacerbated by the lack of clarity of which consultant was responsible, split/ shared on call with locum emergency surgeons and no consultant-of –the week structure. The review team heard of foundation doctors finding it difficult to obtain help from other specialties at weekends with undue delays in responding to requests for input (e.g. Review of patients by Medical Specialties were inordinately delayed).</p> <p>It should be noted that the foundation year trainees felt that they would not recommend their friends and family to be treated at Newham University Hospital (NUH) site in general surgery, but would recommend the training post to their peers in Urology and Trauma and Orthopaedics.</p>	
S1.2	<p><b>Serious incidents and professional duty of candour</b></p> <p>The review team heard that access to Mortality and Morbidity (M&amp;M) meetings were limited due to frequent cancellations.</p> <p>The review team acknowledged the trainee's perception that choice of cases discussed at these meetings were often ad-hoc, appeared to lack coherence with clinical experience of trainees and minimum effort appeared to have been made to share any 'lessons learnt' or curriculum relevant opportunities for the foundation trainees in general surgery.</p> <p>In terms of reporting Serious Incidents (SIs): the review team noted that the foundation year trainees were familiar with the process of raising Datix reports.</p>	
S1.3	<p><b>Rotas</b></p> <p>The educational and clinical supervisors that the review team met with reported that plans were underway to improve learning in emergency surgery and that there were arrangements for a new rota to be implemented in the department so that trainees received predictable rotations.</p>	
S1.4	<p><b>Induction</b></p> <p>The review team heard that the general surgery departmental induction was perceived to be not fit for purpose and comprised usually of an informal chat for Foundation Year one (FY1) doctors combined with a hundred-page document of protocols/ procedures. The trainees were not prepared for the working pattern, departmental structure, timetable, learning opportunities, Professional Development Plans (PDPs), escalation nor encouraged to consider exposure to operating theatres for aspiring surgeons.</p> <p>The trainees indicated that they were not aware of the whistleblowing policy at their Trust induction.</p> <p>The review team heard that foundation trainees had experienced difficulties when accessing hospital information technology (IT) systems.</p>	Yes please see S1.4
S1.5	<p><b>Handover</b></p> <p>The review team heard that foundation trainees working in general surgery often felt unsure of concerns and/or issues with their in-patients and were unclear about their senior surgical supervision. The foundation trainees reported that they therefore felt anxious and unsafe working out-of-hours. Handover was often ad-hoc and between foundation trainees. They were not aware of a robust, senior led and well attended handover meeting at change of shifts (e.g. 8am and 8pm weekdays and 3pm on Fridays).</p>	Yes, please see S1.6

	<p>The foundation trainees reported that the week day consultant-cover and oversight on elective post-operative patients was variable and on an ad-hoc basis. This was echoed by the DDSC who described consultant support as inconsistent during ward rounds.</p> <p>In relation to the handover arrangements in place at the weekend, the foundation trainees reported that handover meetings occurred every Friday afternoon at 3pm, which were occasionally led and attended by the consultant on-call.</p> <p>The foundation trainees indicated that the lack of structure of the handover meetings had occasionally made it difficult for them to establish ownership of patients during weekend shifts. However, the review team was informed that although handover meetings were perceived to be disorganised, most of the foundation trainees reported that they had enjoyed a more formal handover process in the few weeks leading up to this visit.</p> <p>The review team found that the lack of a structured cross-over arrangement for out of hours shifts, was linked to an ineffective handover meeting as described above. This left foundation trainees feeling vulnerable and often unaware of any potential patients at risk of deterioration.</p>	<p>Yes, please see S1.4</p>
<p>S1.6</p>	<p><b>Protected time for learning and organised educational sessions</b></p> <p>The review team heard that foundation trainees in T&amp;O had access to regular trauma and x-ray teachings that were appropriate to foundation year level.</p> <p>The review team heard that local Monday (8am -9am) morning teaching sessions lacked consultant oversight and that the delivery of teaching was fairly unstructured, conceived and delivered by peers with minimal interaction from the consultants, which made sessions ineffective for foundation trainees.</p> <p>The foundation trainees described a culture of 'ad-hoc' consultant ward rounds occurring from four times a day to once a week often repeating rounds already completed by middle-grade doctors. Not all patients were reviewed on consultant ward rounds and often the decision about 'who should be seen' was left to the most inexperienced member of staff. The review team were informed that the general surgery consultants had been allocated time in their job plans to provide ward rounds but found no evidence of a structured consultant ward round timetable. This added to the feeling of uncertainty and anxiety for doctors.</p> <p>The workload appeared to be highly variable between firms. Although the foundation doctors were supportive of each other and willing to share the work-load, there was little evidence of any consultant delivered ward-based teaching or completion of any supervised learning events</p>	<p>Yes, please see S1.6</p>

## 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.**



S2.1	<p><b>Impact of service design on learners</b></p> <p>The review team heard that the service-redesign into an emergency-based structure had impacted on distribution of workload amongst foundation year trainees. Trainees reported that since the introduction of emergency surgical system, learning opportunities had been better, but there was a lack of clarity on which consultant was responsible for each patient, on a day to day plan of work.</p> <p>The review team heard that significant efforts were underway to implement a structured plan for a new emergency surgical cover system.</p>	
<h3>3. Supporting and empowering learners</h3>		
<p><b>HEE Quality Standards</b></p> <p><b>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.</b></p> <p><b>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.</b></p>		
S3.1	<p><b>Behaviour that undermines professional confidence, performance or self-esteem</b></p> <p>The review team was disappointed to hear about a low-level but frequently witnessed/ experienced culture of tolerating B&amp;U from consultants in the general surgery department. The review team recognised that individual trainees affected by this behaviour had access to pastoral support from their educational supervisors, however it found no evidence to suggest that there was satisfactory level of departmental ownership when addressing these issues.</p>	Yes, please see S3.1
<h3>4. Supporting and empowering educators</h3>		
<p><b>HEE Quality Standards</b></p> <p><b>4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.</b></p> <p><b>4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.</b></p>		
S4.1	<p><b>Access to appropriately funded professional development, training and an appraisal for educators</b></p> <p>The review team noted that substantive consultants within the general surgery department were Educational Supervisors (ESs). The Director of Medical Education (DME) reported that all ESs in the department participated in a formal appraisal programme and that their job plans were regularly reviewed to include time for supervision and teaching.</p>	
S4.1	<p><b>Sufficient time in educators' job plans to meet educational responsibilities</b></p> <p>The review team did not receive any evidence of consultant engagement with departmental teaching, completion of supervised learning events, teaching ward rounds, or teaching while in operating theatre/ clinics. The review team heard that there was adequate time allocated to ESs in their job plans to meet educational responsibilities.</p>	Yes, please see S4.1

## 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.

#### S5.1 Regular, useful meetings with clinical and educational supervisors

The review team was informed by the foundation trainees that they did not have a dedicated, weekly session with their clinical supervisors, during which they could complete their requisite competencies and e-portfolio, as well as discuss their progress and any issues that they may have had.

The review team also noted the absence of a robust supportive mechanism in place which would aid foundation trainees in completing their e-portfolios.

## 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.

#### Appropriate recruitment processes

N/A

## Good Practice and Requirements

### Good Practice

- The review team was pleased to hear that there was a rich spectrum of clinical and curriculum relevant opportunities for learning for foundation trainees in Urology and T&O.
- The review team was pleased to hear about the new initiatives in the department for creating a good educational environment, regular teaching, access to operating theatre, clinics and undertaking audits and Quality Improvement (QI) in T&O and Urology.

### Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
S1.1	The Trust is required to provide a written escalation pathway for seeking senior reviews specially for deteriorating patients based on Early Warning Score (EWS), and agreed timelines for a response including seniority required.	The Trust to ensure that an updated escalation policy document be prominently visible in clinical areas, and shared with all general surgery trainees and staff at induction.  Please evidence initial update on HEE monthly action plan submissions by the end of April 2019.	R1.8
S1.6	The Trust is required to implement a structured, consultant led, documented surgical handover meeting with auditable transfer of information between shifts with full attendance from all relevant members of staff. This should include Foundation doctors from Trauma and Orthopaedics (T&O) and Urology providing cross-cover out-of-hours.	The Trust must confirm initial update of this arrangement within five days (please see IMR) with a follow up audit in four weeks that would be regularly monitored via the Surgical Local Faculty Group (LFG).  Please evidence follow up update through HEE monthly action plan submissions by end of April 2019.	R1.4

### Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
S1.4	The department is required to develop a robust, structured induction program which includes senior led overview of assessment of the surgical patient, management of common surgical emergencies, the care of the post-operative patient and protocols for escalation of deteriorating patients.  The induction should clearly set out the duties, expectations and supervision arrangement during on-call shifts. No trainee should be expected to be on call	The Trust to provide evidence of implementation of an improved induction program and submitted to HEE at least 4 weeks before the next cohort of trainees starting in post.  The Trust to provide data on attendance and feedback from trainees to HEE at the earliest opportunity.	R1.13

	out-of-hours before completing this Trust induction.		
S3.1	The Trust's education academy is required to work collaboratively with the general surgery department in ensuring that incidents related to Bullying & Undermining (B&U) are appropriately dealt with and the department moves to a culture of supportive learning.	The Trust to provide evidence of trainee feedback through LFG minutes. Please provide initial update by 18 April 2019.	R1.17
S4.1	The Trust is required to develop a consultant job plan that reflects an agreed schedule of clinical commitments, detailing fixed (daily) ward rounds, attendance at handover, on -call cover expectations and participating in specified educational activity (SPA) including time for supervision.	The Trust to report on arrangements made for clinical cover for the department and provide an update on the Trust's job planning framework as it pertains to the allocation of Supporting Professional Activities (SPAs) for education. Please evidence initial update on HEE monthly action plan submissions by end of April 2019.	R4.2
	The Trust is required to facilitate an early meeting between representatives from HEE and the higher trainees in Trauma and Orthopaedics (T&O) to allow review of the concerns raised by the GMC survey results and cross referencing of the reports received from the educational supervisors.	The Trust to ensure that Higher orthopaedic trainees are available to attend the meeting planned for 25th March 2019.	

### Recommendations

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

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

Requirement	Responsibility

### Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty
Date:	04 April 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.