NHS
Health Education England

Royal Free London NHS Foundation Trust

Urology, Plastic Surgery, and Vascular Surgery

Risk-based review (on-site visit)

Quality Review report

19 March 2019

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	These on-site visits to urology, plastic surgery, and vascular surgery were required for the following reasons: **Urology - t**o explore the reasons behind the GMC NTS 2018 survey that returned four red outliers for Urology at Barnet Hospital for: - Induction - Educational Governance - Rota Design There were also pink outliers for: Overall Satisfaction; Clinical Supervision; Reporting Systems; Work Load; Teamwork; Handover; Adequate Experience; Curriculum Coverage; Educational Supervision; and Feedback. **Plastic Surgery** - requested following ongoing concerns around bullying and undermining behaviour within plastic surgery. **Vascular Surgery** - requested due to ongoing concerns regarding reported incidences of bullying and undermining behaviour within vascular surgery.
Training programme / learner group reviewed	The review team met with: - four foundation year one (F1) trainees and four specialty training year three (ST3) to ST7 trainees in urology; - six educational supervisors (ES') and clinical supervisors (CS') in urology, including the postgraduate lead for urology; - two core surgery training (CST) year two and seven ST3 to ST8 trainees in plastic surgery; - three ES in plastic surgery, including the clinical director; - two F1 and two ST4 to ST5 trainees in vascular surgery; and - four ES and CS in vascular surgery, including the postgraduate lead for vascular surgery. From the Trust management and postgraduate medical education team the review team met with: - Guardian of Safe Working Hours - Director of Medical Education - Deputy Director of Medical Education - Head of Quality Postgraduate Medical Education
Quality review summary	The review team thanked the Trust for hosting and facilitating the review. The review team was pleased to find that the following areas were working well: - the collaborative approach between consultants and trainees in urology that made for a positive and productive environment for education and training; - that core and higher trainees in plastic surgery had good and frequent access to a broad range of operative experience; and

	- that trainees in vascular surgery were encouraged to broaden their skillset and had the opportunity to collaborate with, and gain experience in, interventional radiology. This was a good example of co-training as promoted by Health Education England (HEE) between vascular surgery and interventional radiology. However, the following areas were identified as in need of improvement: - Foundation year one (F1) trainees providing night time cover for the four departments of vascular surgery, general surgery, urology, and trauma and orthopaedics were not always provided with constant close supervision because of core level rota gaps. This was in breach of the requirements of their provisional registration. The review team issued an immediate mandatory requirement (IMR) to the Trust that required it to ensure that constant close supervision was always provided for F1 trainees and where this was not possible, to remove F1 doctors from the night time on-call; - The review team was disappointed to hear that trainees on-call out of hours were required to pay for accommodation, and that if they chose not to pay for this and make use of common rooms/areas the standard of these were poor. It was reported that mice had been sighted and that beds and sofas were infested with mites; - The review team was concerned that foundation year one trainees at weekends worked across urology and orthopaedics and that handover and supervision for orthopaedics was not appropriate due to the demands of covering both specialties; - It was not apparent to the review team that trainees in plastic surgery were aware of, or involved in, a local faculty group; and - The plastic surgery department was challenged to put in place a mechanism for consultant oversight of non-operative cases referred to their emergency service, with a view to improving clinical and educational governance. Following the review, members of the review team met with a member of the Trust's executive team to discuss reports of individual behaviour.

Quality Review Team			
HEE Review Lead	Dr Gary Wares, Deputy Postgraduate Dean, North Central and East London	**Head of School**	Mr John Brecknell, Head of School, London Postgraduate School of Surgery
External Clinician	Mr Dominic Nielsen, Deputy Head of School, London Postgraduate School of Surgery	**Lay Representative**	Jane Gregory, Lay Representative
HEE Representative	John Marshall, Learning Environment Quality Co-ordinator, Quality, Patient Safety & Commissioning Team, London		

Educational overview and progress since last visit – summary of Trust presentation
At the meeting with the Trust management and education leads the review team heard that the Trust was always quick to respond to issues arising out of the General Medical Council (GMC) National Training Survey (NTS), especially where concerns around bullying an undermining behaviour had emerged.

With regard to urology, it was reported that a large redesign of urology services across the Trust dating back to 2015 was still having an impact on the operation of the urology service. During the redesign the majority of urology services were centred at the Royal Free Hospital, with some services transferred from Barnet Hospital. This move had resulted in some consultant and higher trainee posts moving from Barnet to the Royal Free. However, foundation and core surgery posts were not transferred and had put strain on the rotas for these training grades.

It was reported that the Trust had appointed three physician associates (PAs) in urology and that feedback from trainees had been positive, citing that these appointments allowed trainees more opportunities to get to theatre. However, the Trust management did anticipate that the arrangement whereby F1 trainees were expected to cover both urology and orthopaedics out of hours at weekends would be an issue raised when the review team met with that trainee cohort. The review team heard that the Trust was reviewing this arrangement.

The review team heard that the Trust had appointed an education lead for plastic surgery who had had a positive impact on the education and training experience for trainees. It was also reported that a local faculty group (LFG) had been re-established as a forum for addressing trainee concerns. It was also reported that a new education lead had been appointed in vascular surgery who, along with the clinical director, had highlighted where behaviours and interpersonal relationships in the department needed improvement.

In relation to the culture of bullying and undermining behaviour, particularly in vascular surgery and plastic surgery, the review team heard that the Trust had implemented a number of initiatives to encourage trainees and staff to raise concerns and report incidences of bullying behaviour, including the appointment of a deputy Director of Medical Education (DME) with a remit focused on trainee wellbeing. It was reported that clinical education leads and the postgraduate medical education team operated open door policies for the raising of concern and ran a regular drop-in clinic for trainees, as well as promoting the 'Civility Saves Lives' campaign. It was noted that the higher than normal volume of reported bullying and undermining incidents across the Trust more widely may be as a result of the Trust encouraging reporting of them. The review team also heard that the Trust had a charter of Trust values and that where this was breached formal disciplinary processes could be applied.

Asked what steps the Trust took to address specific reported incidences and the individuals at the centre of allegations of bullying and undermining, the review team heard that each case was investigated, and where appropriate, escalated to Board level. In some cases where the incidents had been escalated it was not always clear that the outcomes had been fed back to those concerned appropriately. Whilst the Trust did feel supported by the Board in its attempts to address bullying and undermining, as demonstrated by the appointment of the deputy DME focused on trainee wellbeing, the outcome of Board interventions had not always filtered back to departmental education and clinical leads or the postgraduate medical education team. It was reported that in such cases the Medical Director (MD) had intervened.

The review team heard that the response to reported bullying was felt to be inadequate by some trainees. Where appropriate, the DME had apologised on behalf of the Trust whilst keeping in mind the impact any apology may have on the trainee. The Trust was keen to stress that it treated all cases on a case by case basis, dependent on sensitivity and discretion.

It was felt that rota gaps exacerbated stress and existing tensions within departments. To address this the review team heard that the Trust was looking to expand the number of physician associates across the Trust, citing the impact they had had in urology. However, it was acknowledged that appointing to these roles was difficult due to lack of suitable candidates. To attract candidates the Trust was offering contracts that allowed three months annual leave. It was expected that newly appointed physician associates would fall within the remit of the postgraduate medical education team and have an assigned educational supervisor.

With regard to trainees' exception reporting, the Guardian of Safe Working Hours (GoSWH) felt that the number of reported incidents was relatively low for a Trust of its size. Exception reports that were received were predominantly from foundation training grades. The foundation training programme director was keen to stress that overall the foundation trainee feedback was largely positive but agreed that the urology and orthopaedics weekend cross cover arrangement for F1s would be raised with the review team when it met with trainees. The GoSWH reported that they met with the MD to discuss exception reporting, as well as submitted reports to the Board on a quarterly basis. It was noted that the GoSWH had imposed fines for exception reporting for cardiology and general surgery

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
RFS 1.1	**Patient safety** The review team did not hear of any incidences where patient safety had been jeopardised in urology or plastic surgery. The educational supervisors (ES') and clinical supervisors (CS') felt that the cultural issues within the department and the impact these had across the wider multidisciplinary team (MDT could pose potential risk to patient safety.	
RFS 1.2	**Appropriate level of clinical supervision** **Plastic Surgery** Higher trainees reported good clinical supervision at all times, with one trainee noting that it was markedly improved from when they had worked in the department at an earlier stage in their training.	
RFS 1.3	**Rotas** **Urology** The review team heard that the out of hours service in urology could often be very busy. The higher trainees felt that this was due to the lack of core training grades on the weekend rota. This would often result in the higher trainees 'acting down' where appropriate to fill the gap in the core rota. The F1 trainees reported that whilst the Trust did take steps to address rota gaps by advertising locum shifts they felt that the process for filling these was not suitable as the rota coordinator was often difficult to contact or unresponsive to responses to the advertised shifts. It was also thought that the Trust offered a lower locum rate compared to other trusts, putting it at a disadvantage.	

	Plastic Surgery Higher trainees in plastic surgery reported that they did not receive their rotas ahead of starting their rotations in a timely manner and would have liked this made available to them six weeks in advance of starting their posts. Trainees did recognise that the timely issuing of rotas was a common issue across the wider NHS. Trainees reported that their rotas were clinician designed and allowed for a day off following being on-call and where trainees worked beyond their contracted hours, they did not feel the need to exception report as they generally stayed through choice.	
RFS 1.4	**Handover** The review team heard from the clinical supervisors (CS') for urology that at weekends F1 trainees accompanied the consultant on the morning board round and afterwards would head to orthopaedics following the urology board round. It was recognised that this could be stressful for F1 trainees as often by the time they arrived in orthopaedics they would have missed the board round and the consultants would often be in theatre. It was felt that a lack of familiarity in orthopaedics settings exacerbated the challenge for F1 trainees, particularly with acutely unwell orthopaedics patients. The review team heard of an instance from F1 trainees where inadequate handover had led to three patients being 'lost' in orthopaedics. The situation was resolved within two hours, primarily due to the trainee calling service managers across the hospital to track down the patients. It was felt that the service, supported by F1s cross covering with urology and clinical fellows unfamiliar with the clinical environment, was affected by the gaps in the core rota. **Plastic Surgery** The review team was pleased to hear that a robust handover that discussed all patients from the night team to the day team took place at 07:30. Trainees reported that they found this invaluable.	
RFS 1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** **Urology** Higher trainees in urology reported that they had lots of opportunities to get to theatre, aided by a willingness on the part of the consultants to see patients on the ward whilst trainees went to theatre. Likewise, higher trainees also reported that they had frequent opportunity to attend consultant led clinics. The review team heard that the urology service was split broadly into general urology, kidney and stones, and cancer teams. The review team heard that higher trainees were expected to work at both the Royal Free and Barnet Hospital. Trainees could expect to spend two days per week in theatre with the remainder of the week spent attending clinics, providing on-call cover at Barnet Hospital, and assigned to flexible cystoscopy lists. It was reported that a consultant of the week and a named registrar would address any emergency or unscheduled work, allowing trainees to carry out their assigned duties. The review team heard that the centralised nature of urology services across London meant that trainees would have to move between sites and trusts to get exposure to the full spectrum of urology procedures within the urology programme they would be required to carry out to meet their training requirements, including pelvic cancer cases. However, it was noted that trainees did not feel unduly worried about meeting the number of required index cases, although it was felt that to meet index case numbers there was degree of responsibility on trainees to plan their own training. It was also noted that at times it felt like they were competing with clinical fellows for theatre access. Where trainees had taken it upon themselves to get honorary contracts at other Trusts they had been supported by the Trust. It was agreed among trainees that a hospital passport for index case numbers across trusts would be beneficial.	

	From the CS' the review team heard that the department had a high volume of renal cases go to theatre that foundation grades could attend and assist with. **Vascular Surgery** The review team heard that higher trainees may have limited access to theatre when there is a full complement of trainees. However, this was only apparent at the beginning of their rotations and that once annual leave and sickness absence were factored in there were more opportunities to get to theatre. The review team heard that higher trainees could expect to spend two full days per week in theatre and never had more than two clinics per week. The review team was pleased to hear that all clinics were consultant led and that trainees would not attend clinics if there was no consultant to lead them. The review team was also pleased to hear that trainees had good access to index cases and was particularly pleased to hear that trainees in vascular surgery had the opportunity to work with, and be trained by, interventional radiologists. This was a good example of co-training as promoted by HEE between vascular surgery and interventional radiology. It was reported by the ES' and CS' that a surgical skills course had been implemented, and that there were opportunities for trainees to broaden their endovascular theatre experience at Barnet Hospital and University College Hospital. The review team also heard that trainees had opportunities to take part in simulated training exercises. **Plastic Surgery** The review team heard from higher trainees that their access to a range of procedures was limited as the department did not undertake cleft or burns procedures. However, there were no reported concerns around meeting the required number of index cases. The review team heard that trainees had good access to abdominal reconstruction, lower limb, and breast reconstruction procedures. It was also reported that the Trust provided good opportunity for trainees to be involved in elective aesthetic and cosmetic procedures, although this did not negate the need to complete the aesthetic fellowship requirement set out by the Joint Committee on Surgical Training. Trainees did note that they would like to see an aesthetic component, including cleft, as part of their rotations as standard. Core trainees in plastic surgery reported that they enjoyed their training and had plenty of opportunities to get to theatre and that they had no concerns around meeting the required number of index cases. However, they noted that they did not attend elective clinics, something they felt was a missed learning opportunity. The review team heard from the ES' and CS' that there was a culture of continuous on the job training within plastic surgery, dependent on the engagement of trainees. There was a feeling among the supervisors that some trainees saw clinics as optional and attended them on an ad hoc basis.	
RFS 1.6	**Protected time for learning and organised educational sessions** **Plastic Surgery** The review team heard from the CS' in plastic surgery that there were two protected sessions per week of scheduled educational sessions, one on Tuesdays and one on Fridays. It was reported that there had been a degree of disengagement from consultants regarding teaching sessions but that there was now a new timetable in place with all consultants listed to give two sessions each per year. The review team heard that there had been pressure from service managers within the department to change the timing of the session on Tuesday because of its impact on theatre. One ES was unaware of this pressure and felt that any impact of the teaching sessions at the expense of service demands was minimal. In addition, the review team heard that the was a monthly half day audit exercise that had an education component.	

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.

RFS 2.1	**Effective, transparent and clearly understood educational governance systems and processes** The review team heard that there was a local faculty group (LFG) for urology that had trainee representation. From the ES' and CS' it was reported that trainees were encouraged to exception report and that the importance of this was made clear at induction. The foundation training lead for Urology noted that they met regularly with foundation trainees and that exception reporting was monitored through the LFG. **Plastic Surgery** The review team heard that there had been an LFG in place since the previous HEE review in February 2017. However, it became apparent that core trainees were not aware of, or involved in, the LFG.	Yes, please see RFS 2.1
RFS 2.2	**Impact of service design on learners** **Urology** The review team heard that foundation year one (F1) trainees providing night time cover for the four departments of vascular surgery, general surgery, urology, and trauma and orthopaedics (T&O) were not always provided with constant close supervision on the occasion where a core level rota gap arises during night shifts, which is in breach of the requirements of their provisional registration. It was reported that higher trainees often had to step down to cover core level rota gaps at short notice although it was on occasion not clear to the F1 trainees that this had occurred and that clear lines of supervision were not immediately apparent. Despite the frequency with which this scenario arose the review team heard that there was no guidance or a standard operation procedure (SOP) in place. Where higher trainees worked beyond their contracted hours it was reported that this could have an impact on their ability to work the following day. If they were too tired, higher trainees were encouraged by consultants to go home. This could result in the missing of theatre time. Despite regularly working beyond their contracted hours, the review team heard that higher trainees did not exception report through choice. It was also reported that on-call higher trainees also covered Barnet Hospital. F1 trainees in urology reported that they found the weekend cross covering with orthopaedics challenging, citing being unable to attend the orthopaedics board round as particularly impactful. The review team heard that F1 trainees found it difficult to prioritise their workload and that the bleep was usually busy. They did report however the other medical specialties they worked alongside in orthopaedics settings. F1 trainees reported that they regularly worked beyond their contracted hours at weekends and frequently submitted exception reported. On weekdays F1 trainees reported that they were well supported by the MDT and the urology consultants.	Yes, please see RFS 2.2a Yes, please see RFS 2.2b

	The CS' and ES' recognised that the gap in the rota for core training grades presented an issue for both foundation and higher trainees. They felt that the appointment of physician associates had had a positive impact on the department and on trainees in particular. The review team heard that the Trust was in the process of appointing two more, with offers having been made to successful candidates, and that there was a possibility that with a full complement of physician associates in place that there was scope to possibly include them on the weekend rota to help alleviate the pressures caused by the gaps at core level. It was felt by both the trainees, ES' and CS' that interpersonal relationships between the consultants, trainees, and the wider MDT were demonstrably good and made for a positive education and training environment was due to a lack of departmental 'politics'. However, it should be noted that trainees felt that there was potential for this positivity and goodwill to be eroded by issues such as the issues surrounding out of hours accommodation for on-call trainees. **Vascular Surgery** Higher trainees in vascular surgery were aware of the core rota gaps at night across a number of surgery specialties. The review team heard that the higher trainees did not feel that this impacted them significantly as they were responsible for accepting referrals from the ED and other site managers. The review team was pleased to hear that the higher trainees always made themselves known to the F1 trainees that they would be working with. Where higher trainees stayed beyond their contracted hours they made it clear that this was usually through choice and did not feel the need to exception report. F1 trainees reported that they felt well supported by senior colleagues and that the consultants were all approachable and readily available by phone if not present in the department to offer advice. The ES' and CS' reported that they felt that the department had undergone changes in the last two years that had improved the overall experience for all training grades. The review team heard that the department worked on a firm model and that there had been a reduction from four firms to three. It was reported that there had been a full quota of eight registrars up to the week of this HEE visit, be it training or trust grades, and that there were two registrars per firm. **Plastic Surgery** The higher trainees that the review team met with recognised the impact that the gaps in the core level rota had out of hours that affected vascular surgery, general surgery, urology, and T&O, especially on F1 trainees, but that the impact on higher trainees in plastic surgery was minimal as they were not part of the out of hours service. However, it was reported that on occasion they had been required to fill gaps brought about by the gaps in the core rota. The review team heard that core trainees in plastic surgery were responsible for accepting referrals from the Emergency Department (ED) and from Barnet Hospital, supported by and on-call registrar, and were often the primary referral point for the department. The review team heard that it was common for the emergency hand clinic to be oversubscribed and for the need to run a parallel overspill clinic adjacently. The situation described by trainees raised concerns with the review team that there was not consultant oversight of all cases, including those that were not taken to theatre, presented at the emergency hand clinic. However, trainees felt that the level of clinical supervision was appropriate as a consultant was available in the immediate vicinity of where the clinic was being held.	Yes, please see 2.2c
RFS 2.3	**Organisation to ensure access to a named educational supervisor** **Urology** The review team heard that some higher trainees did not have any outpatient clinics as part of their job plan and as a result felt that they were becoming deskilled. Despite	

	having raised this issue with both their educational and clinical supervisor they had yet found time to meet to discuss modifying job plans to include outpatient clinics.	
RFS 2.4	**Systems and processes to identify, support and manage learners when there are concerns** **Urology** The review team was pleased to hear that in the one case of a never event occurring in urology that the trainee was supported by the ES and CS and accompanied to the meeting with the Trust management. It was reported that there were currently no trainees requiring additional support (TRAS) but where there had been previously the ES' and CS' had felt well supported by the Trust. **Plastic Surgery** ES' and CS' in plastic surgery reported that they had no experience of TRAS but that they were aware of the process and engagement with the postgraduate medical education team.	
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.**		
RFS 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** From all trainee groups that the review team met with, it heard that the arrangements for accommodation for out of hours were unsuitable. Trainees that required an on-call room because they did not live in close proximity to the site were required to pay £50 per night, whilst if they chose not to pay for this and make use of common rooms/areas the standard of these were poor. It was reported that mice had been sighted and beds/sofas were infested with mites	Yes, please see RFS 3.1a and RFS 3.1b
RFS 3.2	**Behaviour that undermines professional confidence, performance or self-esteem** **Urology** Whilst trainees in urology had not experienced or witnessed anything that constituted bullying or undermining behaviour, they did report that relations with the Emergency Department (ED) could be described as 'terse' but that this was understandable due to the stresses involved. The department accepted calls from the ED at Barnet also. Trainees noted that if they ever felt that these exchanges did become inappropriate that they would raise it with their clinical or educational supervisor. **Vascular Surgery** The higher trainees in vascular surgery that the review team met with had not personally been subject to bullying and undermining behaviour. However, they were aware of the reputational culture of bullying and undermining within the department whilst in their previous posts at another trust and harboured some anxieties around working at the Trust due to its reputation. One trainee did note that they did initially feel intimidated by one individual when they first worked together to the extent that it impacted upon their ability and confidence in the operating theatre. To address this the trainee broached the matter directly with this particular consultant and found them to be receptive to these concerns and together	

	sought to address them. Trainees reported enjoying working with and learning from the consultant in question and valued the level of expertise they brought to the training environment. The trainees that the review team met with reported that their experiences in the department did not match the anxieties that they had prior to starting at the Trust and that they had not witnessed a culture of bullying and undermining more widely. However, they were keen to express that they were aware that their experiences did not match that of fellow trainees. Meeting with the education lead and ES' and CS' for vascular surgery the review team heard that the consultant perceived to be the source of the bullying behaviour was in isolation and not reflective of the culture within the department as a whole, which had improved in recent years. It was reported that where bullying had been witnessed that it had been raised with the MD but that the outcomes of any action taken by the Trust were not apparent. With regard to the specific incident involving a trainee the ES' and CS' were not aware of any formal action that had been taken. The group were keen to stress that whilst they did not question the consultant in question's commitment to patient care, the did however feel that impact that their behaviour had on the wider MDT could potentially pose a risk to patient safety. **Plastic Surgery** None of the higher trainees that the review team met with reported that they had witnessed, or been subject to, behaviour that constituted bullying or undermining. All of the trainees stated that they had all worked within the department more than once at varying stages of their training and would not have returned if this had been the case. Core trainees in plastic surgery reported that they found the clinical environment to be supportive and constructive and had not witnessed or been subject to any bullying and undermining behaviour.	
RFS 3.3	**Access to study leave** **Plastic Surgery** The review team heard that higher trainees in plastic surgery had not encountered any problems when booking study leave and annual leave. **Vascular Surgery** The review team heard that higher trainees in vascular surgery had not encountered any problems when booking study leave and annual leave.	
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.**		
RFS 4.1	**Access to appropriately funded professional development, training and an appraisal for educators** **Urology** The review team heard that the ES' and CS' in urology felt that they had support of their managers and the Trust for professional development should they want to become training programme directors.	
RFS 4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The review team heard that the job plans of the ES' and CS' in urology reflected their work commitments toward education and training.	

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.

RFS 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** N/A	

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.

RFS 6.1	**Learner retention** The review team was pleased to hear that trainees of all grades in all specialties that it met with would recommend their respective training posts to their peers.	

Good Practice and Requirements

Good Practice
The review team was impressed by the opportunities for higher trainees in vascular surgery to work with, and be trained by, interventional radiologists. This was a good example of co-training as promoted by HEE between vascular surgery and interventional radiology.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
RFS 2.2a	F1 doctors providing night time cover for the four departments of vascular surgery, general surgery, urology, and trauma and orthopaedics were not always provided with constant close supervision because of core level rota gaps. This is in breach of the requirements of their provisional registration.	Trust is required to ensure that constant close supervision is always provided for this group and where this is not possible, remove F1 doctors from the night time on-call.	R1.7

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
RFS 2.1a	The Trust is required to ensure that all training grades are represented at the LFG for plastic surgery.	Please provide HEE with a copy of the terms of reference and the scheduled dates for the plastic surgery LFG that reflects the involvement of all training grades within two months from the date of issue of this report.	R2.1
RFS 2.2b	The Trust is required to review the weekend day time working establishment to ensure that F1 trainees across urology and orthopaedics have sufficient support to provide safe and effective care to both patient groups.	Please provide evidence of support and handover of patients at weekends to ensure that F1 trainees are supported. This may be in the form of LFG minutes and timetables. The Trust should consider alternative workforce models, including advanced practice roles where possible.	R1.7
RFS 2.2c	The Trust is required to put in place a mechanism for consultant oversight of non-operative cases referred to their emergency service, with a view to improving clinical and educational governance.	Please develop a SOP that shows how the Trust will ensure that there is consultant oversight of all cases brought to the emergency hand clinic within two months from the date of issue of this report.	R1.8
RFS 3.1b	The Trust is required to ensure that trainee common rooms are clean and pest free.	Please provide HEE with a response detailing how the Trust has responded and rectified any issues found with trainee accommodation within two months from the date of issue of this report.	R3.2

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
RFS 3.1a	The Trust is recommended to review the costs associated with trainees requiring overnight accommodation where they are unable to return to base within 30 mins.	Please update HEE on the Trust's plans for on-call out of hours accommodation.	R3.2

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
N/A	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Gary Wares, Deputy Postgraduate Dean, North Central and East London
Date:	3 May 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.