NHS
Health Education England

King's College Hospital NHS Foundation Trust

Foundation Surgery, Trauma & Orthopaedic Surgery and General Surgery

Risk-based Review (on-site visit)

Quality Review report

12 December 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Training programme / learner group reviewed	Foundation Surgery at King's College Hospital (KCH); Trauma & Orthopaedic Surgery (T&O) at KCH; and General Surgery at Princess Royal University Hospital (PRUH)
Number of learners and educators from each training programme	**Foundation Surgery at KCH:** The review team met with: • ten foundation surgery year one (F1) and year two (F2) trainees based in the Acute Surgical Unit and Trauma (ASUT), urology and vascular, orthopaedic, colorectal and upper gastrointestinal (upper GI) surgery at KCH; and • seven foundation surgery educational supervisors (ESs) and clinical supervisors (CSs) based at KCH. **T&O at KCH:** The review team met with: • five core and higher trainees ranging from core training level two (CT2) to specialty training level seven (ST7), and a senior clinical fellow, all based at KCH; and • six T&O CSs and ESs, based at KCH. **General Surgery at PRUH:** The review team met with: • three general surgery higher trainees ranging from ST4 to ST8 based at PRUH; and • four general surgery ESs and CSs based at PRUH. The review team also met with the following Trust representatives: • Deputy Chief Officer • Director of Medical Education • Medical Education Managers • Undergraduate Education Lead • Guardian of Safe Working Hours • Clinical Directors • Training Programme Directors • General Manager – Surgery & Major Trauma • Clinical and educational leads • Medical Education Fellow

Background to review	This Risk-based Review was arranged to discuss the General Medical Council (GMC) National Training Survey (NTS) results for 2019 relating to foundation surgery at KCH, T&O at KCH and general surgery at PRUH. **Foundation Surgery at KCH:** F1 surgery at KCH received eight red outlier results in the GMC NTS for 2019. The red outliers related to overall satisfaction, workload, teamwork, supportive environment, induction, adequate experience and educational governance. This generated eight actions on the Trust's 2019 action plan.

	F2 surgery at KCH generated no data on the GMC NTS for 2019, as an insufficient number of trainees completed the survey. The review team requested to meet with F2 surgery trainees based at KCH to obtain an overall view of foundation surgery training across both years. **T&O at KCH:** T&O at KCH received seven red and seven pink outliers in the GMC NTS for 2019. The red outliers related to clinical supervision, clinical supervision out of hours, reporting systems, induction, curriculum coverage, local teaching and rota design. This generated seven actions on the Trust's 2019 action plan. **General Surgery at PRUH:** General surgery at PRUH received five red and seven pink outliers in the GMC NTS for 2019. The red outliers related to overall satisfaction, adequate experience, curriculum coverage, educational governance and educational supervision. This generated five actions on the Trust's 2019 action plan.
Supporting evidence provided by the Trust	The review team received the following supporting evidence from the Trust in advance of the on-site visit: • Medical and Dental Education meeting minutes from October 2019; • T&O Local Faculty Group (LFG) meeting minutes from February and October 2019; • General Surgery LFG meeting minutes from April and July 2019; and • Supervisor training records for foundation surgery (KCH), T&O (KCH) and general surgery (PRUH)

Summary of findings	The quality review team would like to thank the Trust for accommodating the on-site visit and for ensuring that all sessions were well attended. The review team was pleased to note several areas that were working well: **Foundation Surgery at KCH:** • The review team heard that the foundation trainees thought that the colorectal, urology, vascular and orthopaedic surgery teams created good working environments. The trainees felt well-supported and stated that they had respectful relationships with senior colleagues and were able to attend most teaching sessions. • The trainees said that there were effective handover arrangements and that their training was compliant with guidance, in that they were not required to take consent for procedures outside their remit, they were not required to administer cytotoxic drugs and did not carry out sitemarking prior to surgery. • The review team heard that most foundation surgery trainees would recommend their training posts to colleagues and they would be happy for friends and family members to be treated by the colorectal, urology, vascular and orthopaedic surgery teams. **T&O at KCH:** • The review team was pleased to hear there were solid plans in place to adjust how the T&O service and training within the team was delivered. • The higher trainees in T&O reported feeling well-supervised and supported and they said they received good training. **General Surgery at PRUH:**

	• The review team noted that the general surgery team had undertaken significant work to improve the training timetables to ensure these were compliant with the Joint Colleges of Surgical Training quality indicators. This included numbers of clinic and theatres lists, dedicated time for research and time for private study. Health Education England (HEE) issued one Immediate Mandatory Requirement (IMR) at the visit, in relation to foundation surgery, as follows: • The review team heard that trauma patients on the ASUT were not always reviewed by a consultant on and during their admission, in line with national guidance. There were equally situations where the foundation year doctors were the only doctors reviewing patients at times. This had implications for patient safety and for the safety of the foundation trainees. The Trust was required to put in place arrangements for consultant review, as per national guidance, by way of consultant ward rounds twice daily. A Trust response to this IMR was due on Thursday 19 December 2019. HEE also identified the following areas for improvement, which were verbally shared with the Trust at the visit and shared in writing the following day: **Foundation Surgery at KCH:** • Within the upper GI and ASUT teams, foundation trainees did not consistently receive induction on starting in post. • The foundation trainees working in the ASUT team said that they felt there was a lack of senior supervision at times and their role was largely administrative. • The foundation trainees reported frequently working beyond their rostered hours in the ASUT team. **T&O at KCH:** • The review team heard that the current timetable of the T&O higher trainees was intense and there was no time allocated for research and administration. • The review team heard there were plans in place to implement a new firm structure but not all trainees had had sight of, or input into the new timetables. **General Surgery at PRUH:** • The review team noted that the general surgery team relied heavily on locally employed and staff grade doctors for maintaining service and compliant rotas, which created a risk of reducing access to training opportunities for trainees.

Quality Review Team			
HEE Review Lead	Anand Mehta, Deputy Postgraduate Dean, Health Education England, South London	**Training Programme Director**	Robert Hagger, Training Programme Director for General Surgery, South West London
Head of School Representative	Dominic Nielsen, Deputy Head of School for Surgery, Health Education England, London	**Foundation School Representative**	Jan Welch, South Thames Foundation School Director, Health Education England, South London

Lay Member	Kate Rivett, Lay Representative	**Lay Member**	Kate Brian, Shadow Lay Representative
HEE Representative	Gemma Berry, Learning Environment Quality Coordinator, Health Education England, South London	**HEE Representative**	Louise Brooker, Deputy Quality, Patient Safety & Commissioning Manager (Quality, Reviews and Intelligence), Health Education England, London

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

The review team heard from the foundation surgery training leads, based in general surgery, that they were disappointed but not surprised by the GMC NTS results for 2019, given the pressures the Trust was under (the Trust was in special measures) and challenges around administration processes, physical space and logistics at KCH. They said they had tried to offer a good training experience to foundation trainees based in general surgery, whilst attempting to protect them from Trust issues, but they faced difficulties regarding the bed base for surgery at KCH, which was reviewed as part of the Getting It Right First Time (GIRFT) programme.

The foundation training leads informed the review team that a number of wards had recently been repurposed from surgery to medicine, so surgical patients were spread across a large geography on the KCH site. Whilst the surgical teams were considered to have a 'flat' hierarchy and trainees were supported directly by consultants, this was made more challenging because of the way the patients were distributed across KCH. However, the review team heard that there were immediate escalation processes established within team structures and all CSs and ESs were readily available to trainees.

The foundation training leads said they had implemented changes in response to their NTS 2019 results, and other feedback from trainees, including feedback shared via the Trust's Guardian of Safe Working Hours (GOSWH). These changes included improvements to handover processes, streamlining of ward rounds and procuring of WiFi telephones for trainees' use. A WhatsApp group had also been created for trainees to contact one another and other members of the team more easily. The training leads recognised that administrative support for foundation surgery trainees had been difficult, but a dedicated surgical nurse was now in post to provide additional support for acute cases.

The review team heard that all surgical staff rotated through each of the surgical wards on the KCH site. Unlike the medical wards, there were no physician associates, ward clerks or phlebotomists on the surgical wards (with the exception of the Surgical Assessment Unit (SAU), which had its own dedicated staff and ward clerks available seven days a week). The training leads said they wanted ward clerks on the surgical wards and similarly, a business case had been submitted approximately four years ago to recruit physician associates, but this was put on hold due to the Trust's financial position. The Director of Medical Education (DME) acknowledged that more progress was needed regarding investment in non-medical staffing resources.

The training and educational leads based in T&O told the review team that in early 2018, they lost two foundation-level doctors (taking the establishment from eight to six) and found it difficult to replace them. By the time the NTS was launched in spring 2019, major changes were underway within the team, in response to feedback from trainees and consultants (discussed in their LFG meeting in February 2019). In collaboration with both parties, amendments were made to their timetables, and to consultants' on-call duties and theatre lists. The training and educational leads said they had since been holding more regular meetings with the trainees to discuss these changes and their feedback had been quite positive. The review team also heard that new rostering software had been introduced, which allocated trainees' free rota slots to clinical activity relevant to their training needs. This was overseen weekly by a recently-assigned trainee representative.

The T&O leads advised the review team that there was a proposal in place to change the structure of the T&O team, from six to four firms. It was hoped that this would improve trainees' exposure to learning opportunities, as there would be a senior clinician responsible for training within each firm (training sub-leads) and rota cover would be organised within the individual firms, so trainees would only cover other trainees within the same firm.

The clinical lead for general surgery at PRUH advised that their team was predominantly comprised of Locally Employed Doctors (LEDs), which they thought alleviated trainees' workload. The team had a firm-based

structure and the clinical lead thought that this gave trainees a sense of belonging. The review team was told that the team was trying to ensure higher trainees did not work nights so that they had more training opportunities during the day.

The review team heard that the general surgery team at PRUH was using local Vacancy Approval Process (VAP) but recruitment was better now than a year ago and more doctors were due to join in January 2020, when the team would be at full complement. The clinical lead advised that they had 'clinical assistants' in post within their team, and their LEDs were very proactive. When the team had requested additional LED posts in the past, the Trust had apparently been responsive and the clinical lead considered workforce transformation to be achievable.

The DME added that the Trust was working with some other trusts in London to utilise the apprenticeship levy, and it had subscribed to the workforce transformation 'philosophy' (such as the establishment of non-doctor roles) whilst recognising the challenges of cost improvement plans on staffing. The DME thought that the Trust had more stability and a clearer direction with regards to workforce planning and associated business cases than previously, even encouraging all teams to recruit trainee physician associates. The DME also said that, when business cases were being drawn up and reviewed, consideration was being given to training needs as well as service delivery.

The GOSWH informed the review team that only 10-15% of trainees at the Trust were submitting exception reports and of those reports, only 5-6% related to missed training opportunities. The GOSWH did not think these figures were reflective of reality, but noted that there was no evidence that trainees were being discouraged from exception reporting, and suggested other methods of exploring trainees' issues around working hours. The GOSWH also highlighted that the level of detail on the exception reporting system was variable, so it was difficult to identify the drivers behind the reports, such as staffing and rota gaps. Occasionally, exception reports were submitted relating to immediate safety concerns and these were used to review staffing and rotas in the related departments, in order to develop rotas that accounted for service needs, as well as training.

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive learning experience for service users.

1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.

1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I).

1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.

1.6 The learning environment promotes inter-professional learning opportunities.

Ref	Findings	Action required? Requirement Reference Number
S1.1	**Patient safety** **Foundation Surgery:** The review team heard that when foundation surgery trainees were based in the Acute Surgical Unit and Trauma (ASUT) team, they were rostered to work on either the ASU	

	or in trauma at any given time. If foundation trainees were working on the ASU, they reviewed all ASU patients on a Monday morning ward round with a consultant or a higher trainee, as there were more new patients to review on Mondays than on other days. However, the review team was concerned to hear from the trainees that if a new patient was admitted to the ASU on another day of the week, they were not necessarily reviewed by a consultant. Furthermore, whilst the trainees confirmed they did not assess new patients on their own, they did not always have a more senior clinician overseeing their work. The trainees stated that all new orthopaedic surgery patients were seen by a consultant. Overall, the foundation trainees' experiences of working in ASUT meant that they would not be content for their friends or family to be treated by the team, due to the time pressures of ward rounds, patients not being reviewed by consultants, under-resourcing and their perception that there was a high risk of error. The trainees who had worked or were currently working in urology, colorectal, upper gastrointestinal (upper GI), vascular and orthopaedic surgery all said that they would be happy for their friends and family to be treated by these teams. **General Surgery:** The trainees told the review team that they would be happy to be a patient in general surgery at the Princess Royal University Hospital (PRUH).	Yes, please see S1.1
S1.2	**Appropriate level of clinical supervision** **Foundation Surgery:** The review team heard that when foundation trainees were based in the ASUT team, they did not always feel adequately supervised. They suggested that there were only two consultants who had an interest in working in trauma and who were therefore engaged in supervision for that team. When consultants from other surgical sub-specialties provided cross-cover for the ASUT team, the foundation trainees felt less well-supervised. They also said there were no higher trainees working in the ASUT team at times, so foundation trainees were occasionally left to deal with complex cases autonomously. They expressed the view that senior trainees were better supported than the foundation trainees in the ASUT team. Whilst working night shifts in the ASUT team, the foundation trainees told the review team that there were two surgical higher trainees rostered to supervise - one covering major trauma and another covering general surgery. However, issues had arisen in the past when there was no general surgery higher trainee on shift and the trauma higher trainee had to cross-cover both general surgery and trauma patients (orthopaedic surgery clinicians did not cross-cover trauma at any level). The foundation trainees also said that these higher trainees were often based in theatres, although they were accessible. The foundation trainees thought that the Hospital at Night team was helpful and they confirmed they had access to up-to-date clinical guidelines, but they also felt they could ask more senior trainees for support when required. The review team was informed that foundation trainees based in orthopaedic surgery received support from the physician associates in their team. The supervisors said that the junior Locally Employed Doctors (LEDs) had provided supervision to the foundation trainees when there was a shortage of core and higher trainees in the team. There was also a 'knee' WhatsApp group within the orthopaedic surgery team which all relevant team members responded to when required. However, the trainees felt they received little senior-level support when handling trauma calls. The review team heard that on weekends, there was only one orthopaedic surgery foundation trainee on shift during the day (they did not work nights). On Saturdays, they joined a large ward round led by a consultant. On Sundays, the consultant was in Accident & Emergency whilst the foundation trainee stayed on the ward. Although all new patients were seen by a consultant, the trainees said that they were often the only other doctor on shift treating around 80 to 90 patients.	Yes, please see S1.2

	Overall, the foundation trainees felt well supported by their colleagues and they felt able to ask for advice. Similarly, one of the supervisors said that they were always happy to assist trainees, but they were aware that when teams were busy, foundation trainees did not necessarily receive optimum support from their colleagues. Another of the supervisors based in the ASUT team said they were aware that foundation year one (F1) trainees should not be left unsupervised and they were developing a teaching programme and support from junior LEDs to address this problem (the junior LEDs were, in turn, receiving support and direct instruction from the consultants about this). The supervisors told the review team that the F1 trainees had created a private Facebook page to share useful information among themselves and the trainees had direct access to, and immediate responses from, consultants via WhatsApp when required. **Trauma & Orthopaedic Surgery (T&O):** The review team heard from the higher trainees in T&O that their consultants and colleagues were supportive, accessible and approachable. They were not left alone to undertake work beyond their competency levels and they felt well supervised in clinic, theatres and whilst on call, both in the day and at night. They had not experienced any problems contacting consultants at night. **General Surgery:** The review team heard that some of the consultants, LEDs and specialists in the team were very supportive and some of the consultants were good trainers. Some of the trainees said that they felt well supported with regards to elective surgery and emergency cases whilst on call.	
S1.3	**Responsibilities for patient care appropriate for stage of education and training** **Foundation Surgery:** The foundation trainees confirmed that they were not required to administer cytotoxic drugs and did not carry out sitemarking prior to surgery.	
S1.4	**Taking consent** **Foundation Surgery:** The foundation trainees confirmed that they were not required to take consent for procedures outside their remit. **T&O:** The T&O trainees told the review team that they were not asked to take consent from patients if they were not confident to do so.	
S1.5	**Rotas** **Foundation Surgery:** The review team heard that when foundation trainees were based in the ASUT team, their working hours were variable and their workload could be quite intense if there were a large number of patients to manage, alongside rota gaps. They said that some foundation trainees had left the ASUT team (although it was not clear how many or when this happened) and they had not been replaced, so there were continual rota gaps. The trainees also informed the review team that they were often expected to work beyond their rostered hours. When working in trauma, their day time shifts were supposed to end at 17:00 but the trainees reported that it was rare to leave on time and that they usually left at 20:00, due to the high number of patients to be treated. A number of the trainees said they submitted exception reports when they worked beyond their rostered hours in the ASUT team, due to workload, although some	Yes, please see S1.5a

	expressed scepticism as to whether exception reporting would lead to improvements. One of the trainees described an instance where a consultant suggested that it was not appropriate to submit exception reports at the start of the placement, implying an expectation that trainees would work additional hours while learning the job. However, the trainees thought that the consultants and higher trainees recognised that the team was under-resourced and they helped to fill rota gaps when they could. This was reiterated by the supervisors, who said they were trying to arrange as much support for the teams as possible, but their rotas had been stretched over the past few months. The review team was told that the foundation trainees based in the ASUT team were rostered to work nights, which involved covering ASUT, upper GI, vascular surgery, urology and colorectal surgery. The foundation trainees based in colorectal surgery and orthopaedic surgery did not work nights. The foundation trainees said that their working hours in the orthopaedic surgery team were fine. However, there were two foundation-level vacancies in the team, which meant they were understaffed and had to see approximately 80 to 90 patients per day. Those trainees who had been, or were currently, working in colorectal surgery thought their team was well-staffed and they had good working hours. They said that the foundation trainees held the bleep, which the higher trainees did not get involved with. With regards to foundation training in the upper GI team, the review team heard that the trainees sometimes worked later than their rostered hours, until 19:00 or 19:30, as there were not enough staff to manage the busy workload. They said that most of the consultants had their own assigned higher trainees and saw their own patients, but the foundation trainees joined the ward rounds and accumulated tasks from those. **T&O:** The review team heard that the higher trainees' rotas were altered in January 2019 due to staff changes. There were currently seven higher trainees and a number of LEDs in the team. The higher trainees said that, as a result of the rota alterations, they had stopped working 24-hour on-call shifts. They explained that on weekdays, a senior LED was on-call with a junior trainee (F2 or core surgical trainee) from 08:00 – 20:00, Monday to Friday, and then the higher trainees sometimes covered weekday night shifts on-call, taking the weekends off. At other times, the higher trainees covered weekend nights from Friday to Sunday, finishing on a Monday morning with Tuesdays as zero days. They also covered day shifts on-call along with Saturday and Sunday day times, taking the following Monday as a zero day. The core trainees' rotas were mainly based on on-call shifts, with two-week blocks of ward cover, five days per week. Whilst there were opportunities to attend theatre, there were no clinic sessions timetabled for them to attend and at the end of a two-month block of ward cover, the review team heard that they only had eight days available for other learning opportunities. The higher trainees informed the review team that when they had entered their rota arrangements into the British Medical Association (BMA) 'RotaChecker', their working hours were non-compliant. They said that covering one in eight on-call shifts was a tight frequency and the higher trainees' rota also did not match the junior trainees' rota. On average, when not on-call, each higher trainee had three or four theatre sessions timetabled per week but, in general, they did not think they had enough rostered time in theatres. Rota arrangements meant that the higher trainees were not always rostered to be working at the same time as more senior colleagues who could offer them learning opportunities in theatres. They thought that some of their rotas were 'clinic-heavy' (on average, five clinics per week) but this was not consistent between the trainees because it was dependent on their assigned consultants' arrangements, and sometimes they were required to cover other clinics on an ad hoc basis. The higher trainees advised the review team that they usually had an available session in their rotas to use as they wanted, but this was often overtaken by other duties. They did not have any set time allocated for research or administration and they usually dealt with administration outside of their rostered hours.	Yes, please see S1.5b Yes, please see S1.5b

	One of the trainees explained that the T&O team was planning to implement a 'superfirm' system to help with the coordination of new rotas. There would be four firms between 30 consultants, with rotas for each firm. This meant that each firm would have more autonomy and there would be a greater focus on allocating rota sessions based on trainees' learning requirements rather than service provision. Two new foundation-level LEDs had been recruited to increase the foundation doctor base from six to eight and alleviate pressure on the on-call rotas, and new rotas were due to be implemented in early 2020. Whilst the trainees expressed hope that this would improve their rota arrangements and supervision (particularly for core surgical trainees, who were not currently assigned to any consultants), the higher trainees were concerned that continuing to work night shifts would mean they were away from their main day time duties for a week at a time, and zero days across the firms would lead to rota gaps. It was suggested that the team needed more junior doctors to make the 'superfirm' system work effectively. The supervisors in T&O agreed that the 'superfirm' structure required increased staffing but not necessarily more trainees. They also suggested the trainees had preferential rota arrangements over the LEDs in the new rota proposals, but it was important to satisfy both parties. It was thought this might be helped by having the two new foundation-level LEDs in post soon, to alleviate on-call rota arrangements by having two junior LEDs per firm. As mentioned above, the trainees described how, at present, rota coordinators filled rota gaps with higher trainees, which meant they were reallocated from theatre sessions to cover clinics on an ad hoc basis. Trainees felt that the coordinators and managers were focussed on service provision rather than training needs and they would benefit from a trainee representative reviewing the rotas. However, by implementing the 'superfirm' system, the trainees hoped that those within each firm would have more opportunity to discuss and swap rota arrangements between themselves where necessary. The supervisors said that the 'superfirm' structure meant that leave, timetables and cross-cover would be managed by one person within the firm and arrangements would be more predictable, albeit more restrictive. The higher trainees reported that junior trainees were often unavailable for on-call shifts. The higher trainees sometimes took on the responsibility of finding someone to fill these rota gaps, because they found that the service managers did not always address these issues in a timely manner. However, they thought that this situation had improved recently due to better staffing within the team, and the 'superfirm' structure could help to address these challenges. The review team heard from the trainees that they had not initially been asked to formally input into the development of the new T&O 'superfirm' proposal and rotas, but the consultants were understanding of their training needs and there was a plan to let them review the proposals and provide feedback in due course. However, the supervisors said that the arthroplasty and sports firms had been co-designed with the current trainees and LEDs and they were content with the proposals. Most trainees had been given an indication of how the firms would be structured, but not all firms had been finalised. One of the higher trainees highlighted that their consultant had discussed the new rota arrangements with them and they appeared to have made educational considerations, but BMA compliance was still to be addressed. There were plans to incorporate fixed weekly administration and research sessions into the trainees' rotas and any free sessions would be specifically allocated to clinical work. **General Surgery:** The review team was informed that there were currently three higher trainees and 15 LEDs in the general surgery team at PRUH. The higher trainees described how they were rostered to cover one on-call day time shift every second week and one weekend in eight, and these weekend shifts alternated between days and nights. They said that LEDs worked night shifts in the week and sometimes at weekends. The supervisors explained that the latest rota	Yes, please see action S1.5c

	arrangements had been discussed with the trainees in early 2019 and they had decided they wanted to take two zero days after working nights on a weekend. The higher trainees were each working in different consultant firms, all of which had a senior LED, and their rostered time in clinic varied from two to four sessions per week, also dependent on whether they were on-call. The higher trainees were rostered to attend between one and three theatre sessions per week, but this was also variable due to the number of clinicians in the firms looking to get experience. They said that rostered theatre time for trainees had always been low in the team, but this had reduced significantly over the past few years as the team recruited more LEDs and the work was split between more people. The supervisors said that if trainees had learning opportunities available to them in theatre, they were not pulled out to cover a clinic; this theatre time was protected. They also said that on a theatre list, if both a trainee and LED were present, the trainee would generally be the one to operate. However, this was dependent upon the trainee's level of experience. The supervisors thought that the current on-call rota arrangements allowed trainees more freedom and exposure to theatres, so they had not received negative feedback from the trainees in this regard. The trainees stated that there had been issues with backfilling members of the team who had left, which had impacted upon on-call arrangements. They described situations when they had been on-call with no junior trainees to support them, so they had had to hold two bleeps. They also said that the more junior trainees in the team did not do post-take ward rounds, so they had to ask trainees from other teams to assist with on-call duties.	Yes, please see S5.1
S1.6	**Induction** **Foundation Surgery:** The foundation surgery trainees advised that they had not received an induction on joining the upper GI team or ASUT team, although in ASUT, trainees received a one-hour lecture by a consultant on how to access help. On joining the orthopaedic surgery team, the trainees said that they had received a useful induction, led by a consultant, although this did not cover pharmacy. They also received a handbook written by previous F1 trainees. They had been given the opportunity to share feedback on their induction. The foundation trainees all said that they had received a Trust induction on commencing their posts at King's College Hospital NHS Foundation Trust. **General Surgery:** The supervisors told the review team that they organised an induction programme every six months to introduce their trainees to endoscopy.	Yes, please see S1.6
S1.7	**Handover** **Foundation Surgery:** The foundation trainees said that when they started a day shift in the ASUT team, the foundation trainee who had been on the night shift handed over to them. However, consultants and higher trainees conducted their own handovers separately, including handing over new patients between themselves. The foundation trainees said that they were not directly informed about new patients by the consultants and higher trainees, although they were aware that discussions were taking place. The review team heard that when foundation trainees in upper GI surgery were rostered to work a long day, they handed over to the foundation trainee on the night shift. Consultants and higher trainees held handover discussions between themselves. There was also a separate surgical on-call team and foundation trainees did not have any involvement in their work or discussions. The review team heard that at 20:00 every evening, all night staff would meet in a conference room and conduct handover	

	discussions as a group, led by the higher trainees. They said this was a very structured and educational meeting, including the review of scans and blood test results. **General Surgery:** The review team heard that whilst on-call during the day, the rostered higher trainee would be in theatre and then have overall responsibility for the take. However, it was noted that there could be up to three doctors conducting independent admitting processes for the team during the day and it was often difficult for trainees to identify which patients had been admitted. As a result, the trainees said that it was not uncommon for patients to get 'lost' from the list or to find out about an admission at late notice on a shift. This was particularly the case for patients referred by Accident & Emergency or GPs via the bleep held by the junior trainees. It was suggested that handover processes would be more effective if there was one shared list they could access showing all of the admission information across the team, but they had not found it easy to suggest changes to processes that had been embedded in the team for a long time. The trainees also advised that handover arrangements from day shift to night shift doctors had been problematic at times because the junior trainees and LEDs did not always attend the handover meetings. However, they said that this had improved recently and the morning handover meetings were good. The review team heard that the consultants in the team saw all acute admissions and after the post-take ward round consultants conducted ward rounds most days.	
S1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** **Foundation Surgery:** The foundation trainees expressed the view that, when based in the ASUT team, only around ten per cent of their daytime duties had educational value, as they did not have the opportunity to assess patients (patients were reviewed by more senior trainees). Foundation trainees said they mainly provided administrative and secretarial support for trauma surgery, such as requesting scans, or writing ward round notes, and there was only occasional phlebotomy work, as surgical wards tended to process their own bloods. The trainees stated that they sometimes assessed patients whilst on call in the evening, but they did not get the opportunity to go to theatres and they said there was no one available to assess their work. The review team heard that the more senior trainees in the ASUT team had greater access to educational opportunities than the foundation trainees. The foundation trainees said that whilst training in orthopaedic surgery, they did not take bloods but they produced discharge summaries and examined patients on a daily basis. They were encouraged to attend theatres and clinics if they were on top of their main duties and if there were lower numbers of clinicians due to be in attendance. Trainees in the vascular surgery team were also encouraged to attend clinics and theatres Whilst working in the upper GI surgery team, the trainees reported having a similar experience to those in orthopaedic surgery (although theatres and clinics were not mentioned), but they also produced discharge summaries for patients that were known to them. The review team was told that the urology team was busy but supportive towards foundation trainees. The trainees said that they had opportunities to assess patients under supervision, including new patients, and to attend clinics as part of their training. Some of the foundation surgery supervisors said they offered trainees the opportunity to scrub into theatre with them, to get exposure to anatomy and to finish procedures, in order to develop their basic skills. For emergency cases, they said the trainees were taught how to approach patients. However, the supervisors said that only 20 per cent of their trainees actually took up their offer to attend theatre and gain practical skills.	Yes, please see S1.2

	Some of the supervisors told the review team that they arranged face-to-face meetings with each of their trainees, to share feedback on their performance, which was formalised through the trainee's e-portfolio. They also discussed what the trainees wanted and needed to achieve in their posts and learning opportunities were arranged accordingly, although it was important that the trainees engaged in that process. The supervisors appreciated the need for trainees to meet minimum competencies but beyond that, they asked the trainees to decide how they wanted to spend their time; for example, if a trainee wanted to become a GP, their supervisor would ensure they had learning opportunities relating to the musculoskeletal pathway, as this was something they would need in the future. One of the supervisors expressed the view that, even if trainees did not want to specialise in surgery, it was still important for them to get exposure to learning opportunities in theatre and to understand sequelae. The supervisors had not heard that the foundation trainees were unhappy with undertaking administrative duties, although they were aware that some trainees found writing discharge summaries tedious. The supervisors thought that these tasks were a fundamental part of the F1 role and helped to demonstrate that trainees had a good grasp of patient care and the linkage between secondary and primary care. They also thought that producing discharge summaries for interesting cases was valuable learning. However, they did arrange for junior LEDs to help with the foundation trainees' work and to swap bleeps with them if it meant they could undertake tasks they were interested in. They thought that the foundation trainees' learning opportunities were better than they were two years ago, as the increased support from other trainees and LEDs in covering the wards allowed more time to discuss cases, as well as alleviating stress by reducing workloads. The review team recommended that the proportion of administrative tasks undertaken by the foundation trainees was reviewed against other educational opportunities, to enable a balance between both. The review team also suggested that doctors' assistants, rather than physician associates, could be beneficial to the teams, as they could work to the foundation trainees and cover some of their administrative duties, enabling the trainees to take advantage of the educational opportunities available locally. The supervisors said that the ASUT team had raised this suggestion with the Trust already, and the urology team was exploring workforce options to include physician associates and doctors' assistants. The review team advised that Health Education England's Workforce Transformation Team could work with the Trust to facilitate the introduction of these roles.	Yes, please see S1.2
S1.9	**Protected time for learning and organised educational sessions** **Foundation Surgery:** The foundation trainees informed the review team that one-hour weekly teaching sessions were scheduled for all F1 trainees and two-hour monthly teaching sessions were scheduled for F2 trainees. Overall, the trainees thought that their teaching sessions met their curriculum requirements over the course of the year and they were able to attend these. However, those in the ASUT team said that there had been some exceptional circumstances when it had not been feasible for them to attend teaching sessions due to the demands of service provision. The review team heard that local teaching sessions within the surgical teams were variable, ranging from brief ad hoc discussions with higher trainees to more in-depth formal meetings on a regular basis. In the ASUT team, a small multi-disciplinary team meeting was held every week but trainees advised that this was not actively publicised. At each meeting, the team discussed four or five interesting cases, talking through the patients' pathways and scans. The trainees thought this meeting should have been advertised more widely. **General Surgery:**	

	The review team heard from the general surgery trainees that they were always able to attend formal teaching sessions in London and they had access to quality improvement work and audits. One of the colorectal surgery supervisors told the review team that they arranged and sponsored training course places for the trainees. They also held weekly 90-minute teaching and handover sessions on Friday afternoons, for trainees to discuss cases and to voice any concerns.	
S1.10	**Adequate time and resources to complete assessments required by the curriculum** **General Surgery:** The trainees in general surgery told the review team that they had conducted workplace-based assessments and their supervisors were happy to complete these. The supervisors thought that the trainees were meeting their curriculum requirements.	
S1.11	**Access to simulation-based training opportunities** **Foundation Surgery:** The review team heard that the F1 trainees based in urology spent four hours every other week with the postgraduate simulation lead at King's College Hospital (KCH). One of their supervisors thought this was a reason why the trainees enjoyed their posts in urology.	
S1.12	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** **Foundation Surgery:** All of the foundation trainees confirmed that they had regular meetings with their educational supervisors. **General Surgery:** All of the trainees said they knew their educational supervisors and had made educational plans for their training year. One of the educational supervisors in colorectal surgery said they met with their assigned higher trainee three times a week, outside of a clinical setting, to discuss their progress and to get feedback on how their training could be improved. They also asked the trainee to write a short summary every two months outlining what they had achieved over that period, rather than waiting till the end of the year. They said that the team's supervisors promoted an open-door policy for trainees to voice their concerns or to ask for anything they needed.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.

2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.

2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.

2.4 Education and training opportunities are based on principles of equality and diversity.

2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

S2.1	**Effective, transparent and clearly understood educational governance systems and processes** **Foundation Surgery:** None of the foundation trainees were aware that Local Faculty Group (LFG) meetings were being held and they did not know who their foundation trainee representative was at the Trust. They said there was a junior doctor forum in place, but this was not educational. Overall, the foundation trainees felt able to raise concerns with their consultants and other senior colleagues, who were generally receptive and supportive. The foundation surgery supervisors said they held regular supervisor meetings for both educational and clinical supervisors to escalate any concerns, or to ask for support and advice from colleagues, for example around trainees in difficulty. **T&O:** The review team heard that there was a LFG in place for T&O. The trainees said they were unsure how receptive their team leads would be to feedback regarding the new rotas and 'superfirm' structure proposed for 2020, as they had tried to raise concerns about their rostered zero days during the previous year and felt that these had not been addressed (although it was not stated in which forum this feedback had been shared). The T&O supervisors advised that changes were being made to their team's structure in response to feedback from trainees, although it was not clear how this feedback had been collected. **General Surgery:** The trainees told the review team that a LFG meeting had been held last week, but not all of them had attended one of these meetings, nor had they been aware of them in the past. The supervisors said they promoted open communication within the team, so that trainees felt able to voice concerns. They also had a WhatsApp group that the trainees could use to share their thoughts (although it was not stated who was part of this group) and they said the trainees could speak with them any time.	
S2.2	**Impact of service design on learners** **Foundation Surgery:** Some of the foundation trainees said that, whilst working in the ASUT team, they missed out on educational opportunities as a result of delivering service provision and felt overworked, with no time to take lunch breaks. They said that the ASUT team needed to expand its workforce, as the patient base was increasing and staffing had not increased accordingly. The trainees suggested recruiting doctors' assistants, as they would be able to alleviate some of the administrative burden from the foundation trainees and allow them to access more educational opportunities. Whilst working in the upper GI team, the trainees said they sometimes had to roam the KCH site to review their patients. Similarly, they described how the orthopaedic surgery patients were scattered across multiple areas of the hospital, although the patient management system was kept updated with their locations and no patients had been lost. The foundation trainees thought that the Trust's laboratory service worked well and the radiology service was very good, although it took them a couple of weeks to understand some of the processes for ordering scans.	
S2.3	**Systems and processes to make sure learners have appropriate supervision** **Foundation Surgery:**	

	The review team heard from the supervisors that, because the foundation surgery trainees sometimes worked across several teams, they would occasionally raise issues with their supervisor that related to a team the supervisor wasn't based in or responsible for. The supervisors said they were addressing this matter with the Director of Medical Education (DME) and they were receiving good support from the Medical Education Team overall. One of the issues that had been raised was a potential lack of support for trainees in the ASUT team. **T&O:** The review team heard that core surgical trainees in T&O were not based in a consultant 'firm', so it was difficult to maintain regular clinical supervision arrangements; they could work for up to five or six consultants in a week. It was suggested by the trainees that they needed more consistent supervision to be able to progress with their training. However, the review team was informed that the core surgical trainees' supervisors were supportive and it was hoped that the new 'superfirm' structure for T&O would improve this situation. Similarly, the T&O supervisors said that, following a reorganisation of the team in early 2019, their allocation of trainees had changed and they were now supervising a different trainee each day of the week, leading to continuity issues. 'Flexible' sessions had been introduced to rotas to meet service needs, all managed by a central organiser, but this had caused some disruption. The team was due to move back to a 'superfirm' structure shortly, meaning there would be fixed set of trainees, LEDs and consultants within each firm. Cross-cover and supervision would only be limited to those firms and it was hoped this would improve continuity.	

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 to achieve the learning outcomes required.

3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.

3.3 Learners feel they are valued members of the healthcare team within which they are placed.

3.4 Learners receive an appropriate and timely induction into the learning environment.

3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

S3.1	**Behaviour that undermines professional confidence, performance or self-esteem** **Foundation Surgery:** None of the foundation trainees reported being bullied or undermined in the workplace and overall, they felt their colleagues were supportive. However, the review team heard that some of the trainees in orthopaedic surgery had experienced some unreasonable and unpleasant behaviour from the senior nursing staff, who called the foundation trainees repeatedly outside of the times the trainees were rostered to deal with calls. This issue was apparently well-known by the team but it was not stated whether any action was being taken to address it. **General Surgery:** The review team was informed by the trainees that some sub-teams or firms within general surgery were comprised solely of consultants and LEDs, some of which were the most senior teams in terms of expertise and experience. The review team heard that relations between the trainees and some of the LEDs and sub-teams were not always easy and in some cases, there was an underlying feeling of 'us and them'. The trainees said they had tried to identify the root of these tensions, but this had not been possible.	

	At the latest LFG meeting in December 2019, the review team heard that the group had discussed some concerns and issues within the team, and possible solutions, but the tensions described above were not mentioned. However, the trainees thought that the consultants were aware of the tensions between the LEDs and trainees. The supervisors thought there were good relationships within their teams across all staff grades, but they said they did not take this for granted and made sure they held regular meetings to address any issues. They also thought that, even with an open forum to discuss issues, some of the team were hesitant to talk about 'clashes' between trainees and LEDs and there was occasionally an undercurrent of tension. In some instances, the consultants had received feedback from individuals privately, rather than in a group setting, and reported that they had taken action to address their concerns. Some concerns had been related to more experienced individuals not sharing their knowledge with colleagues to help their learning.	
S3.2	**Academic opportunities** **Foundation Surgery:** The review team was told that four F1 trainees in vascular surgery had recently undertaken projects and presented abroad. The supervisors also said they made their trainees aware of research opportunities, audits and projects should they want to get involved, but some trainees were more engaged than others.	
S3.3	**Access to study leave** **General Surgery:** The review team heard that some of the trainees had booked study leave and were satisfied with the process for this.	
4. Supporting and empowering educators		
HEE Quality Standards **4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.** **4.2 Educators are familiar with the curricula of the learners they are educating.** **4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.** **4.4 Formally recognised educators are appropriate supported to undertake their roles.**		
S4.1	**Access to appropriately funded professional development, training and an appraisal for educators** **T&O:** The T&O supervisors confirmed that they received educational appraisals and the DME was proactive with arranging these across KCH and PRUH.	
S4.2	**Sufficient time in educators' job plans to meet educational responsibilities** **Foundation Surgery:** The foundation surgery supervisors confirmed that they had protected time in their job plans for education and training (0.25PA per trainee), including teaching on ward rounds. They said that in some instances in the past, training had been undertaken on an ad hoc basis, but the supervisors had pushed to have this time recognised by the Trust.	

	The review team heard that as part of their job plans, the supervisors in urology each supervised at least two trainees at foundation, core or higher training level. **General Surgery:** One of the educational supervisors told the review team that educational responsibilities were built into their job plans, but their roles were becoming busier and more pressured. This made it more difficult to take a fixed half-day each week for such duties, so they said they tried to use all interactions with trainees as educational opportunities.	

5. Delivering curricula and assessments

HEE Quality Standards

5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.

5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.

5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

S5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** **T&O:** The review team heard from the trainees in T&O that overall, they did not have the opportunity to independently operate at KCH as often as they had at other Trusts and they felt they did not spend enough time in theatres to meet their curriculum requirements. They suggested this was partly because the team received more complex cases than at other Trusts, requiring more senior expertise, but also because the T&O team had a larger number of trainees and LEDs, who were all competing for the same learning opportunities and experience. The trainees advised that the T&O team took an egalitarian approach to trainees and LEDs; their educational needs were considered to be the same. Both groups had good working relationships within the team, and the trainees thought that if they began to receive preferential treatment in terms of learning opportunities, things could become difficult. However, they often ended up attending more clinics than the LEDs, rather than theatres, as a result of the arrangements within the team. The trainees said that on occasions when they were rostered to be in theatre at the same time as another trainee or LED at a similar level, they had to divide cases between them, which affected their overall learning and practical experience. The review team was also informed that in some instances, the theatre team was comprised of a lead consultant, second consultant, two higher trainees or LEDs and then a fourth assistant, such as a core surgical trainee. Therefore, the core surgical trainees had fewer opportunities to become first assistants and gain more direct experience. Some of the trainees said that their indicative case numbers were very low whilst training at KCH. At times, they were not rostered to be in the main theatre at all, or only had one operating session per week, and some trainees took the opportunity to attend theatres in their rostered administration time instead. They expressed concern about meeting their indicative numbers in future. The review team heard that the T&O consultants were aware of the above issues and thought there was a potential need to recruit more senior LEDs to take on the supervision of trainees, so they could gain more practical experience in theatres. However, funding had not yet been secured for this. Physician associates were based in T&O, whom the trainees thought could help to alleviate the core trainees of some of their duties, allowing them to spend more time in	

	theatres and gain practical experience. However, they acknowledged that some of the physician associates also wanted to gain surgical experience, which could create further competition for access to theatre lists. Overall, the trainees thought that the new 'superfirm' system proposed for 2020 was likely to increase their learning opportunities and practical experience and thought that if the consultants had more control over their own firms and training, they could potentially implement more beneficial changes. **General Surgery:** The review team heard that the higher trainees in general surgery had experienced difficulties accessing learning opportunities and gaining practical experience in theatres, particularly for elective surgery and oncoplastic surgery (although their emergency case numbers were on target). They said they were occasionally rostered onto a theatre list together, and at times they had had to split a small list of three patients between them and a LED, so the practical experience was reduced. However, this point was contradicted by the supervisors, who said the trainees performed the operations in these situations. In other instances, trainees reported that parts of surgical cases were allocated to different members of the theatre team, so they were not always able to perform substantial parts of operations or parts that were relevant to their curriculum requirements. The review team also heard that some of the trainees had only been rostered to attend three major theatre cases in two-and-a-half months, so they had arranged to cover extra on-call shifts on their zero days and at weekends to increase their numbers and get the experience they required. They reported issues accessing endoscopy lists due to timetable clashes, although these had recently been resolved. The trainees highlighted that on occasion, they had looked at consultants' theatre lists, contacted managers to find an available anaesthetist to support them, and operated on patients with a consultant either directly supervising them or at least on site, so they could increase their case numbers. The trainees said that consultants were usually helpful with finding surgical cases they could join, but the trainees preferred to be involved in the allocation process and this did not always happen. The trainees thought they had to be proactive and self-motivated to find the cases they needed to meet their curriculum requirements and some cases were difficult to find at PRUH, for example laparoscopic cholecystectomy. One of the colorectal surgery supervisors told the review team that arrangements had been made for the PRUH trainees to spend time at KCH every fortnight, to give them exposure to cases they needed for their training. Overall, the trainees thought that they had done as much as they could to address their limited learning opportunities and practical experience, but they were concerned the situation would not change because of the staffing structure currently in place. One of the colorectal surgery supervisors thought that the current consultant firm and staffing structure worked well for their team, as they were able to assess when a trainee had enough practical experience to complete a full procedure on their own and to design the trainee's rota based on their training needs and theatre time. However, they acknowledged that it had not always been possible for trainees to attend endoscopy sessions due to understaffing within the team. The review team heard that the supervisors, and in particular the new clinical lead in the team, had improved the theatre list allocation process to address these issues, and to offer as many theatre sessions to trainees as possible. This was considered to be more challenging when firms had both senior trainees and senior LEDs, as sometimes the senior LEDs could work more independently than the senior trainees, but the supervisors aimed to create learning opportunities for both groups. They also expressed the view that LEDs and trainees had different training needs, although this was not elaborated on. One of the supervisors based in breast and endocrinology said that they held a firm meeting every Monday when they allocated cases to trainees and LEDs, depending on their training needs.	Yes, please see S5.1 Yes, please see S5.1

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.

6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs to patients and service.

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

S6.1	**Learner retention** **Foundation Surgery:** The foundation trainees told the review team that they would recommend their training posts to colleagues, with the exception of the ASUT and upper GI surgery teams. The review team was concerned to hear of the negative impact of the heavy workload in the ASUT team on some trainees. Training in upper GI surgery was not recommended due to the perceived lack of support from senior colleagues and educational opportunities available to the foundation trainees.	

Good Practice and Requirements

Good Practice
N/A

Immediate Mandatory Requirements

Given the severity of an Immediate Mandatory Requirement, the risk rating must fall within the range of 15 to 25 or have an Intensive Support Framework rating of 3. This risk rating will be reviewed once the Trust has provided their response to the Immediate Mandatory Requirement.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
Foundation Surgery (King's College Hospital (KCH)):			
S1.1	We heard that trauma patients on the Acute Surgical Unit and Trauma (ASUT) were not always reviewed by a consultant on and during their admission, in line with national guidance. There were equally situations where the foundation year doctors were the only doctors reviewing patients at times. This has implications for patient safety and for the safety of the foundation trainees.	The requirement is that the Trust put in place arrangements for consultant review, as per national guidance, by Thursday 19 December 2019, by way of consultant ward rounds twice daily.	S1 / R1.2 & R1.9

Mandatory Requirements The most common outcome from a quality intervention. The risk rating must fall within the range of 8 to 12 or have an Intensive Support Framework rating of 2.			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
Foundation Surgery (KCH):			
S1.6	Within the upper gastrointestinal (upper GI) and ASUT teams, foundation trainees should consistently receive induction on starting in post.	The Trust is to provide the induction programmes for foundation trainees joining the upper GI and ASUT teams. The initial response to this action is required by 1 March 2020, in line with Health Education England's (HEE) action plan timeline.	S1/R1.13
S1.2	The foundation trainees working in the ASUT team should have senior-level supervision at all times. Their administrative tasks should be balanced with educational opportunities.	The Trust is to provide evidence through Local Faculty Group (LFG) minutes and/or trainee feedback by 1 March 2020, in line with HEE's action plan timeline.	S1/R1.8
S1.5a	The foundation trainees should not be working beyond their rostered hours in the ASUT team.	The Trust is to provide evidence through LFG minutes and/or trainee feedback by 1 March 2020, in line with HEE's action plan timeline.	S1/R1.7
Trauma & Orthopaedic Surgery (T&O) (KCH):			
S1.5b	The intensity of the T&O higher trainees' rotas should be reduced and they should have protected time for research and administration.	The Trust is to provide T&O rotas by 1 March 2020, in line with HEE's action plan timeline.	S1/R1.12
S1.5c	All trainees should have sight of and input into the new T&O firm structure and rotas.	The Trust it to provide evidence through T&O LFG minutes and/or trainee feedback by 1 March 2020, in line with HEE's action plan timeline.	S2/R2.3
General Surgery (Princess Royal University Hospital):			
S5.1	Training opportunities for trainees should be reviewed and planned with their supervisors in line with their curriculum requirements.	The Trust is to provide written evidence of processes to ensure trainees have planned training opportunities to meet their curriculum requirements. This evidence is required by 1 March 2020, in line with HEE's action plan timeline.	S1/R1.7

Minor Concerns Low level actions which the Trust need to be notified about and investigate, providing HEE with evidence of the investigation and outcome. Given the low level nature of this category, the risk rating must fall within the range of 3 to 6 or have an Intensive Support Framework rating of 1.			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**

	N/A		

Recommendations These are not recorded as 'open' on the Trust action plan so no evidence will be actively sought from the Trust; as a result, there is no requirement to assign a risk rating.		
Rec. Ref No.	**Recommendation**	**GMC Req. No.**
	N/A	

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 Anand Mehta, Deputy Postgraduate Dean, South London
Date:	14 February 2020

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.