NHS
Health Education England

Bart's Health NHS Foundation Trust (Royal London Hospital)

Foundation Surgery and Plastic Surgery

Risk-based review (practice approach)

Quality Review report

20 January 2020

Final report

Developing people for health and healthcare

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Quality Review details

Training programme / learner group reviewed	Foundation Surgery and Plastic Surgery at the Royal London Hospital (RLH)
Number of learners and educators from each training programme	The review team met with 10 foundation year one (F1) trainees on rotation in general surgery and working in the vascular, colorectal, trauma, upper gastrointestinal and hepatic pancreatic & biliary (HPB) surgical teams. The review team also met with five trainees in plastic surgery, including core surgical trainees (CSTs) and higher trainees at specialty training level eight (ST8). In addition, clinical and educational supervisors from both general surgery and plastic surgery participated in the review, as well as the following Trust representatives: • Chief Medical Officer • Divisional Director, RLH site • Trust Dean for Education • Director of Medical Education, RLH site • Deputy Director of Medical Education, RLH site • Deputy Director, Education and Quality • Associate Director for Quality, Medical and Dental Education • Head of Postgraduate Medical and Dental Education • Head of Undergraduate Medical and Dental Education • Medical Education Manager • Service Manager, General Surgery • Service Manager, Plastic Surgery • Clinical Director, Surgery • Educational Lead, Plastic Surgery • Clinical Lead, Plastic Surgery • Clinical Skills and Simulation Leads • Undergraduate Clinical Education Fellows.

Background to review	The quality review was planned by Health Education England (HEE) in response to a deterioration in the 2019 General Medical Council National Training Survey (GMC NTS) results. Plastic surgery training at the Royal London Hospital site returned six red outlier results in the following areas: handover, induction, reporting systems, curriculum coverage, educational governance and study leave. Foundation year one (F1) surgery training at the site received four red outlier results, in the following areas: overall satisfaction, adequate experience, rota design and induction. The department had previously been reviewed by HEE twice in 2019 (specifically foundation surgery and general surgery) and action plans had been put into place. The current review was also planned to ascertain the progress which had been made since the previous review and whether the issues identified had been addressed and resolved.

Supporting evidence provided by the Trust	Internal briefing paper, including: • Summary of GMC NTS results • Workforce and staffing information including trainee numbers • Exception reports summary • Summary of teaching programme • Freedom to Speak Up Guardian summary • Serious incident numbers, including those involving trainees • Numbers of complaints • Friends and Family test summary data • Staff survey data • Educational governance summary, including information from local faculty group and Medical Education Committee meetings • Update on actions taken since the previous HEE quality review.

Summary of findings	Several areas of good practice were reported, including the training and supervision offered to foundation trainees in the trauma surgery team, the improved foundation teaching programme, the significant overall improvement in plastic surgery training and the development of non-medical roles within the plastic surgery team (see Good Practice section for further details). The review team identified the following areas requiring improvement in relation to foundation training: • The F1 trainees found that strict adherence to a firm structure and an insistence by some consultants on reviewing only their named patients impacted negatively on patient care and training. Trainees described instances where patient discharges were delayed and a lack of clarity around which consultant to escalate concerns to if a patient's named consultant was not available. • The trainees described the system of ward-based care as overly complex, with confusion around the remits and responsibilities of junior doctors at different grades and non-medical colleagues. • The review team heard of a lack of consistency between firms in terms of the frequency of consultant ward rounds, despite a Trust policy that all wards should have daily consultant-led ward rounds. • The review team was concerned about the high workload of trainees assigned to certain firms and the significant lack of senior supervision at times. This was impacting on safety of patients and trainees and the team advised an urgent review of this arrangement jointly with the Foundation School. • F1 trainees were rostered to work a phlebotomy shift approximately once per month. This activity did not appear to have any educational value and the review team advised that this practice should cease. The Trust required a robust and sustainable system of close supervision and support for F1 doctors in certain firms in order to ensure consistent care for all surgical inpatients. The review lead informed the Trust representatives that if this was not achievable, then a reallocation of F1 doctors away from these firms may be necessary. In collaboration with the Bart's Health Education Academy, HEE planned

	to monitor the progress of this issue via local faculty group meetings chaired by the Deputy Director of Medical Education and a follow-up quality review in April 2020. The review team identified the following areas of requiring improvement in plastic surgery: • The Trust was encouraged to work with the London Postgraduate School of Surgery when rolling out the new surgery strategy, particularly when planning the movement of services which will necessitate cross-site training. • There were a wide range of specialist theatre lists which could provide valuable learning opportunities for CSTs. The Trust was advised to consider implementing solutions such as incorporating more non-medical roles into the team, altering the Hospital at Night arrangements or reallocation of duties to ensure that CSTs were able to access these lists.

Quality Review Team			
HEE Review Lead	Indranil Chakravorty Deputy Postgraduate Dean Health Education England	**Foundation School Representative**	Keren Davies Foundation School Director North Central and East London Health Education England
Head of School Representative	John Brecknell Head of School, London Postgraduate School of Surgery Health Education England	**Trainee/Learner Representative**	Jack Kingdon Foundation Trainee Guy's and St Thomas' NHS Foundation Trust
Lay Member	Kate Rivett Lay Representative	**HEE Representative**	Louise Brooker Deputy Quality, Patient Safety and Commissioning Manager Health Education England
Observer	Naila Hassanali Quality, Patient Safety and Commissioning Officer Health Education England		

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

Foundation Surgery

The review lead requested a summary of the action taken by the Trust following the release of the GMC NTS results. The Foundation Training Programme Director (FTPD) outlined the improved teaching programme for foundation trainees, which included weekly ward-based teaching, the introduction of the Systematic Training in Acute illness Recognition and Treatment in surgery (START) course during the main induction period in August, weekly formal teaching, simulation sessions and access to educational meetings and morbidity and mortality meetings. The FTPD noted that the ward-based teaching sessions had been nominated for an award within the Trust. Once in every four-month rotation block, the department ran a foundation training day which included simulation training and provided an opportunity to sign off competencies and workplace-based assessments. The review lead enquired whether simulation training was run by the simulation team or by consultants and the

FTPD reported that the majority was led by the simulation team. The review team heard that the teaching sessions had good attendance and that responsibilities on the wards rarely prevented trainees from attending as most of the patients were stable enough not to require constant medical input and there were specialist nurses in some teams who could cover some tasks.

There was a local faculty group (LFG) in place which was minuted, and a weekly drop-in session for trainees to escalate concerns. The FTPD advised that the department had implemented a 'buddy' system to provide additional support for trainees.

The review team was advised that most surgical teams had a 'consultant of the week' model or were working toward a similar arrangement. The purpose of this role was to ensure there was a consultant focused on inpatient care who could provide a clear point of referral and escalation for junior doctors in each team. The review team heard that the department mandated daily consultant ward rounds during the week for each team. In general and vascular surgery there were nurse specialists who participated in ward rounds and could take on tasks such as arranging scans. The Trust was training physician associates (PAs) but at the time of the review there were no PAs in the surgical teams. Some teams had introduced additional core or higher training-level roles to help cover workloads and provide additional support to the foundation trainees.

It was acknowledged that workload intensity was high in certain teams and the department had previously trialled a ward-based rota structure to address this, but had found that a team or firm-based structure worked better so had moved back to this. Acute and ward work had been separated in the rota, so foundation trainees gained experience in the surgical acute unit rather than having 'hot' weeks in the rota. The FTPD reported that the department had worked with the Guardian of Safe Working Hours (GoSWH) to ensure that foundation trainees were aware of their hours, the importance of attending training and how to exception report. The review team heard that there was an expectation that all foundation year on (F1) trainees in surgery would attend at least two clinics and two theatre lists during their four-month rotation.

Plastic Surgery

The GMC NTS had highlighted issues around handover, teaching and induction, which were discussed. The Service manager advised that handover had previously taken place in a small space assigned to the dermatology team, which meant that the plastic surgery team was not always able to use it and that handover could be rushed due to the pressure of vacating the room on time. The team had now been allocated a seminar room for handover each day which allowed more time, more space and had projection equipment so the team could review scans and photographs together when discussing patient cases. The Service Manager noted that this made handover more beneficial for teaching as there were more detailed case discussions.

Previously, formal teaching had been infrequent as it had been difficult to ensure regular, protected time. The review team was informed that a weekly formal teaching session had been implemented, where a junior doctor presented on a pre-set topic linked to the consultant of the week's specialism. Trainee feedback had raised access to study leave as an issue. It was reported that the online rota system would automatically reject study leave requests if a certain number of trainees were already due to be on leave, so the department had implemented an escalation policy to ensure that these requests were reviewed and the system could be overridden, for example if multiple trainees needed to attend the same course. The review team heard that the plastic surgery trainees did not have a formal simulation teaching programme but that they were able to attend the Master's students' microsurgery simulation sessions.

In response to trainee feedback, the department had formalised the induction programme and created a pack which was sent to trainees in advance of their start date giving information about the hospital and about important processes such as booking leave. The new induction programme also included a tour of the department and opportunities to meet the consultants, nurses and therapists.

The review team noted that previous trainee feedback had indicated difficulty in accessing consultant supervision as consultants were rostered to be off-site while supervising or had conflicts between ward work and seeing private patients. The Clinical Lead reported that this had been addressed and that consultants on call were expected to lead on teaching and complete daily ward rounds. The Trust representatives were not aware of any cases where consultants on call had failed to review a patient when requested.

Overall

The review team asked about plans to introduce physician associates and other non-medical roles into the surgical teams. The Trust representatives agreed that progress around this had been slow but that there was work underway to look at how these roles could be incorporated and some of the newer consultants in the team had prior experience of working with physician associates so were enthusiastic about taking this forward.

The department had Educational Fellows working on quality improvement projects around training, such as creating a new surgical skills course in conjunction with the foundation trainees and developing the weekly formal surgery teaching. It was agreed that the Trust would send the review team information on the remit of the Educational Fellows.

The review lead enquired about the new Trust surgical strategy and the likely impact of this. It was reported that the strategy was still in development. The Trust provided assurance that HEE would be provided with updates as work around the strategy progressed.

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
FPS 1.1	**Appropriate level of clinical supervision** **Foundation Surgery** The foundation year one (F1) trainees commended the supervision and overall training experience in the trauma team, highlighting the support from other team members, access to senior doctors and teaching opportunities. The trainees advised that even at weekends when there were fewer staff on shift they still felt well-supported. In other areas trainees reported experiencing variable levels of support, often depending on whether there were sufficient staff on the rota. The review team heard that during on call shifts the F1s could escalate issues to the on call higher trainee, and during day shifts there was usually a core surgical trainee (CST) or higher trainee to seek support from, although this might be delayed if the higher trainee was in theatre. If the F1 trainees required assistance more quickly they could contact the surgical trainees' WhatsApp group or the on call medical higher trainee.	

	The trainees advised that some consultants wished to maintain ownership of their named patients' cases, which extended to a reluctance to make decisions or treatment plans for patients assigned to other consultants. This led to an inconsistency in the frequency and remit of consultant ward rounds, with trainees describing some shifts where they would do rounds with two or three different consultants who would see only their named patients, some shifts where a consultant conducted a full round of the team's inpatients, and other shifts where there was no consultant-led round. If there was no consultant-led round, the higher trainees and F1 trainees would conduct rounds together. The trainees advised that they had escalated these concerns to the rota coordinator. The foundation supervisors reported that, to their knowledge, all teams in the department had consultant-led ward rounds, in accordance with Trust policy. The supervisors stated that in cases requiring specialist input they would refer to a patient's named consultant, but that in general the consultant allocated to the wards for each team should be prepared to make decisions regarding all the team's inpatients. The supervisors advised that the department had worked to address the issues identified at the previous review around disproportionate workloads between teams and the high number of exception reports from foundation trainees. The department had introduced an additional CST-level junior doctor to each team and was trialling having a higher-level junior doctor to 'float' between the teams to help relieve workloads. The supervisors indicated that F1 trainees were encouraged by consultants to leave on time and that if trainees from the day shift were present when the consultants did evening ward rounds, they would be instructed to go home.	Yes, please see FPS1.1
FPS 1.2	**Responsibilities for patient care appropriate for stage of education and training** **Plastic Surgery** The trainees reported an excellent range of learning opportunities in the department, particularly around complex theatre cases. The higher trainees described a good balance of access to clinical supervision with the ability to work independently within their competence. The higher trainees suggested that the CSTs' access to theatres could be increased by allowing them to operate alongside senior trainees more, which would allow the higher trainees to share their learning and help to prepare the CSTs for ST3 roles. The CSTs acknowledged that this would be difficult to arrange within the current staffing structure, but thought that the department could incorporate non-medical roles such as advanced nurse practitioners to improve ward cover. When they were able to attend theatres, the CSTs reported that the experience was excellent. Due to the range and number of theatre lists available, the trainees thought that there was capacity to increase access to theatres without creating competition between trainees. The review team heard that trainees and LEDs on the same rota were treated equitably in terms of access to learning opportunities, allocation to wards and theatres, and on call commitments. The trainees felt that the LEDs were well-supported by the consultants and that the team was able to accommodate junior doctors at various different levels of competence and seniority.	
FPS 1.3	**Rotas** **Foundation Surgery**	

	The hepatic, pancreatic and biliary surgery (HPB) firm had an allocated 'consultant of the day' and the vascular and trauma teams had a 'consultant of the week'. The supervisors reported that in HPB the named consultant each day conducted a ward round along with the higher trainee allocated to day shifts on the ward that week and the F1 trainee. At 16:00 each day, the supervisors advised that there was a follow up paper-based round involving the consultant and both trainees where all patient cases were discussed. The supervisors indicated that consultants would allocate tasks to the trainees and provide supervision and support as needed, although they were unsure whether this was consistent across the consultant body. The review team heard that rota gaps were not always addressed even if they were reported in advance and that there had been errors with allocations to the online rota planning system which had led to issues with on call rotas not aligning with leave and other shifts. In cases where there was no F1 trainee or CST in one team, the trainees advised that the F1 trainee from another team would cover both sets of duties. The trainees were aware that a vacancy in the F1 rota had been filled but the successful candidate was yet to start in post. There appeared to be confusion over the timing of the evening shift, as F1 trainees were rostered to work until 20:00 on these shifts, but reported that some higher trainees had told them that they needed to stay and handover all patients on the list in detail, which meant that they worked for an additional hour. Additionally, the trainees indicated there had been disagreement over the F1 trainees' role when on call at weekends for the general and vascular surgery teams, in terms of whether the F1 trainee accompanied the vascular on call doctor on ward rounds or whether they attended the general round and were then allocated tasks for vascular surgery patients. It was noted that this role also involved being on call for patients at the St Bartholomew's Hospital site and for new admissions. The trainees advised that there was no written policy or rule on this issue so they felt caught between the competing priorities of other members of the team. The supervisors stated that at weekends there was a consultant to see deteriorating patients and all patients from the vascular surgery take with the F1 trainee, and a higher trainee or LED who did a full ward round for all non-acute inpatients. The supervisors noted that the rota included a second F1 to cover general surgery with the higher trainee and a third to cover the trauma team with a clinical fellow.	Yes, please see action FPS1.3
FPS 1.4	**Handover** **Foundation Surgery** The review team heard that at weekends handover took place at 08:00 and included the higher trainees from the night shift and the day shift, the post-take consultant, post-take team and the F1 trainee allocated to acute cover. For the F1 trainees allocated to other areas, the day shift did not start until 09:00 and there was no formal handover. Instead the trainees were given a list of patients and of tasks which needed to be done, which they thought was sufficient for the non-acute wards. The supervisors reported that the consultant always attended handover unless they were in theatre, in which case the higher trainee would cover. The trainees advised that all general and vascular surgery patients were seen during ward rounds on Friday and this formed the basis for the weekend list. However, the list did not include details of patients' named consultants and trainees reported that they did not have access to the vascular surgery consultant rota, so it was not always clear which consultant to contact regarding particular patients. The supervisors noted that	Yes, please see action FPS1.4

	the list was produced from a database which was separate to the main patient records system but that it was not possible to link them. **Plastic Surgery** The trainees advised that there was a formal handover each morning, including at weekends, and a second handover at night which was sometimes in a group setting but sometimes took place between the trainees covering the day and the night shifts. At 13:00 each weekday there was a multidisciplinary team (MDT) meeting which included nurses, clinical nurse specialists, hand therapists, consultants and trainees. .	
FPS 1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** **Foundation Surgery** Most foundation trainees reported that they had been into theatre and had observed in clinics, although not all had. The opportunity to attend theatre and clinics appeared to depend on whether the individual trainee's team was well staffed, and the supervisors acknowledged that this was the case. When trainees were able to access theatres and clinics, they described excellent teaching and learning experiences. **Plastic Surgery** The CSTs reported that their procedural experience was sufficient to meet most of their curricular requirements. The supervisors were aware that it was more difficult for CSTs to obtain sufficient numbers of certain procedures such as tendon repair and skin cancers and suggested that this was largely because the rota restricted their access to certain lists. The CST level rota was staffed by eight junior doctors, including locally-employed doctors (LEDs). The supervisors stated that CSTs and LEDs were allocated equal responsibilities and access to theatres. The review team suggested that reallocating some responsibilities on the wards to the LEDs, introducing cross-cover arrangements at night to reduce the on call commitment or increasing the number of non-medical roles within the team could help to allow the CSTs more time in theatre. The supervisors agreed that there had been some progress in creating non-medical roles in the team which had proven beneficial for service provision and training and that there was capacity to develop this further. The review team enquired whether the department might, in future, be able to accommodate higher trainees at specialty training levels three to five (ST3 to ST5). The supervisors suggested that the department was a good place to train for trainees who had particular interests in subspecialties, so it tended to attract more senior trainees preparing for consultant posts. However, the supervisors thought that the department could accommodate more junior trainees.	Yes, please see action FPS1.5
FPS 1.6	**Protected time for learning and organised educational sessions** **Foundation Surgery** The foundation trainees reported that they were able to complete workplace-based assessments and that the weekly bedside teaching sessions were helpful in allowing them to do this. The trainees found these sessions useful but advised that they were not bleep-free and that on occasions when the wards were busy, they had felt the need to stay late to compensate for time spent at teaching. Foundation training took place on a Wednesday and all the trainees reported that they were able to attend and that it was bleep-free. The Thursday morning teaching session began at 07:30 so trainees	

	could find this more difficult to attend, as it required another trainee to be present on the ward to prepare for the shift and assemble the patient list. The supervisors added that the Systematic Training in Acute illness Recognition and Treatment for surgery (START) course had been incorporated into the induction period in August and that there were plans to run this at different points in the year to coincide with other rotation and induction periods. The supervisors also noted that there were many other non-formalised educational opportunities for trainees, such as regular e-portfolio reviews, attending theatres, teaching on ward rounds and joining clinics.	
FPS 1.7	**Access to simulation-based training opportunities** **Plastic Surgery** The trainees were aware of the simulation centre but were unsure of whether they were able to use it or if it was only open to learners on specific courses who had paid for access. The supervisors advised that trainees would need to schedule time in the centre but that this resource was free to use for trainees.	
FPS 1.8	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** **Foundation Surgery** Some F1 trainees had initially found it more difficult to meet with their educational supervisors (ESs), which they suggested was due to their placements starting during December when the hospital was busy and more people were on leave. However, in general the trainees were able to access their ESs when they needed to.	

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.

FPS 2.1	**Effective, transparent and clearly understood educational governance systems and processes** **Foundation Surgery** The supervisors acknowledged that the firms functioned quite separately and suggested that it would be helpful to have a trainee representative present at department meetings to raise issues from trainees across the firms. **Plastic Surgery** The review team heard that the Education Academy had offered support to the department while the new Educational Lead transitioned into post. The supervisors had worked in conjunction with the Education Academy to address the areas of	Yes, please see action FPS 2.1a

	concern highlighted by the General Medical Council National Training Survey (GMC NTS), including setting up a formal weekly teaching programme and conducting monthly audit meetings which were open to trainees. The review lead enquired about the likely impact of the Trust's new surgery strategy document on plastic surgery training. The supervisors advised that the main changes would be the reorganisation of services between sites, so that emergency cases and complex surgeries, such as those involving multiple subspecialty teams, would be managed at the Royal London Hospital site. It was thought that consultants and trainees in plastic surgery might spend one day per week in day surgery at one of the other Trust sites. The review team advised the Trust to work with the London Postgraduate School of Surgery to develop robust plans for training and supervision for trainees working across multiple sites.	Yes, please see action FPS2.1b
FPS 2.2	**Impact of service design on learners** **Foundation Surgery** The F1 trainees were unclear about the current team structure in terms of ward cover, as they advised that the details were kept on a spreadsheet which they had lost access to in December 2019. The composition of each team was different, with some having more senior support than others and some incorporating non-medical roles such as nurse practitioners. The number of inpatients also varied, meaning that ward rounds for some teams could include review and follow up for 40 or 50 patients. The trainees found that if ward rounds were not conducted in the morning and there were high numbers of patients, they were unable to complete all the necessary tasks and finish work on time, unless they were prepared to handover a list of work to the colleague on the evening shift. Additionally, the trainees advised that it was not possible to refer patients for certain investigations, such as magnetic resonance imaging (MRI) scans in the afternoon, so if rounds finished late they would have to complete such tasks the next day, potentially delaying clinical decision making. **Plastic Surgery** During overnight on-call shifts, the trainees reported that the workload was usually manageable and that they were typically able to rest at some point in the shift. The team included a clinical nurse specialist (CNS) and a trauma coordinator, which the trainees found very helpful as these individuals were able to perform complex dressing changes, assist with some clinics and carry out administrative tasks such as booking patients onto theatre lists.	
FPS 2.3	**Appropriate system for raising concerns about education and training within the organisation** **Foundation Surgery** Trainees experience of exception reporting was variable, with some stating that they felt discouraged from submitting exception reports and some stating that their reports had been well-received and they had had the opportunity to discuss them with supervisors. The F1 trainees were aware of the weekly 'open door' session but advised that it was difficult to attend due to workload on the surgical wards. The trainees felt that the monthly trainee feedback meeting was a useful forum and that issues raised there were escalated.	

	The supervisors reported that they received the minutes of the local faculty group (LFG) meetings as they were not all able to attend, but that otherwise it was difficult to develop a sense of the training experience outside their individual teams.	

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.

FPS 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** **Foundation Surgery** The F1 trainees found the level of support from consultants and other junior doctors variable, often depending on which subspecialty team they worked in. It was reported that certain individuals were very supportive and helpful, particularly among the junior doctors, but that consultants could seem harder to access. Trainees sometimes felt that the consultant of the day or week was reluctant to advise on patients for whom they were not the named consultant. Trainees found this particularly difficult in the HPB team where there was a new consultant in charge each day, making it more complex to determine which consultant to escalate questions or concerns to. The supervisors were aware that the current cohort of trainees were under pressure due to workloads and a rota gap, and that there had been cases of long-term sickness among the trainees. The supervisors agreed that it was important to provide pastoral support to the trainees, but it was not clear whether there was a plan in place to ensure this. **Plastic Surgery** None of the CST or higher trainees reported experiencing any bullying or undermining behaviour, noting that the consultants in the team were approachable and supportive. The trainees were aware that in the past there had been issues with consultants not being absent from the ward or site while nominated to supervise trainees, causing difficulties with escalation and accessing supervision. However, none of the current trainees felt that this was a problem now, and stated that they had always been able to discuss cases with supervisors and request patient reviews or supervision in theatre when needed.	Yes, please see FPS3.1

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.		
FPS 4.1	**Sufficient time in educators' job plans to meet educational responsibilities** **Plastic Surgery** The supervisors reported that the department had recently completed the job planning process for all consultants, and that all supervisors had 0.25PA (programmed activities) allocated per trainee up to 0.5PA. In reality, the supervisors acknowledged that it was challenging to find a regular time for supervision activities and that they often met with trainees when the opportunity arose, such as prior to theatre lists or after clinics.	
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.**		
FPS 5.1	**Appropriate balance between providing services and accessing educational and training opportunities** **Foundation Surgery** The F1 trainees reported that they were rostered to the Day Surgery Unit approximately once per month to carry out phlebotomy duties for patients awaiting elective procedures in general and vascular surgery. The trainees found this shift to lack in educational value and suggested that there was also little benefit to the service as a dedicated phlebotomist would complete the work more quickly.	Yes, please see action FPS5.1
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.**		
	Not discussed at this review	

Good Practice and Requirements

Good Practice

Foundation Surgery

The review team acknowledged the impact of active intervention by the clinical and educational leads on the training environment within the trauma team. Trainees working within the team reported a positive experience which included good access to teaching opportunities, supportive supervision and access to senior doctors.

The review team noted the improved teaching programme, including weekly consultant-led bedside teaching, weekly foundation surgery teaching and the START course which was offered as part of trainee induction in August. Foundation doctors reported that they were encouraged to attend theatre lists and clinics during their rotation.

The department had a local faculty group which held regular, minuted meetings including representation from trainees.

The review team heard that there was progress being made in developing non-medical roles within the general surgical teams, such as specialist nurses.

Plastic Surgery

There had been significant improvements made in the plastic surgery team since the previous Health Education England review in terms of trainer engagement and overall trainee experience.

It was reported that the previous concerns around lack of access to supervision due to consultants being off-site or absent had been resolved. Trainees praised the supervisors for providing an appropriate level of supervision while allowing trainees to develop a sense of autonomy at more senior grades.

The team had incorporated a clinical nurse specialist and a trauma coordinator, who managed some of the clinical and administrative tasks on the ward, which would otherwise have taken up much of the CSTs' time.

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.
	None		

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.
FPS1.1	The department requires consistent implementation of the policy regarding consultant ward rounds.	Please provide a copy of the policy and trainee feedback or LFG minutes demonstrating that the policy is consistently applied across all teams within general surgery.	R1.8
FPS1.3	The department is required to produce a written document outlining the F1 trainees' roles and remits when on call at weekends.	Please provide a copy of this document and evidence that this has been shared with all consultants and junior doctors on the on call rota.	R1.12
FPS1.4	Trainees in general and vascular surgery require access to the vascular consultant rota.	Please provide evidence that this rota has been shared with the trainees.	R1.8

FPS3.1	The department is required to provide clarity around consultants' responsibilities for reviewing patients during ward rounds and ensure that there are clear pathways of escalation for all patient groups, whether this is via each patient's named consultant or the rostered consultant of the day or week.	Please provide evidence that this information has been clearly stated and shared with all consultants and junior doctors in the department.	R1.8
FPS5.1	The F1 trainees should not be rostered for phlebotomy shifts as this activity has no educational value.	Please provide rotas and trainee feedback confirming that this practice has stopped.	R5.9

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.
	None		

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.
FPS1.5	The plastic surgery team is advised to consider ways to improve CSTs' access to theatre lists, for example reallocating duties within the medical team or to other, non-medical colleagues, or reviewing the Hospital at Night arrangements to increase the CSTs' weekday shifts.	R1.15
FPS2.1 a	The Trust is advised to include a trainee representative at general surgery departmental meetings in order to raise awareness of training issues across the firms.	R2.7
FPS2.1 b	The Trust is advised to work with the London Postgraduate School of Surgery to develop plans around cross-site training. This will impact on trainees in plastic surgery initially but will eventually involve trainees in other firms and at all levels including foundation training, so may also require input from the Foundation School.	R2.3

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

Requirement	Responsibility
The Trust is requested to share documentation outlining the remit of the Educational Fellows within the department with the Deputy Postgraduate Dean.	Trust
The Trust is requested to share the 'Surgical Strategy' document and implementation plans which are designed to impact on all surgical services and training across the four Trust sites.	Trust

Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Indranil Chakravorty
Date:	3 March 2020

What happens next?

We will add any requirements or recommendations generated during this review to the Quality Management Portal. These actions will be monitored via our usual action planning process.