NHS
Health Education England

HEE Quality Interventions Review Report

Croydon Health Services NHS Trust (Croydon University Hospital)

Core Surgical Training (CST), Foundation Year Two (F2) Surgery and GP Surgery Training

Risk-based Review (learner and educator review)

London Quality, Reviews & Intelligence Team

4 November 2020

Version Final

Review Overview

Background to the Review:	This risk-based review was arranged to discuss the General Medical Council (GMC) National Training Survey (NTS) results for 2019 relating to foundation year two (F2) surgery and general practice (GP) surgery training, and core surgical training (CST), at Croydon Health Services NHS Trust (Croydon University Hospital (CUH)). F2 surgery training at CUH received three red and one pink outlier (negative results) on the GMC NTS 2019. The red outliers related to overall satisfaction, teamwork and induction. The pink outlier related to adequate experience. GP surgery training at CUH received three red and eight pink outliers on the GMC NTS 2019. The red outliers related to overall satisfaction, adequate experience and local teaching. The pink outliers related to reporting systems, teamwork, handover, supportive environment, induction, curriculum coverage, educational supervision and rota design. CST at CUH received two red and two pink outliers on the GMC NTS 2019. The red outliers related to supportive environment and local teaching. The pink outliers related to overall satisfaction and adequate experience.
Training Programme/Learner Groups Reviewed:	• CST (including trainees on the Improving Surgical Training (IST) programme) • F2 surgery • GP surgery
Who we met with:	The review team met with: • six F2 and GP trainees based in general surgery and trauma and orthopaedic surgery (T&O); and • five core surgical trainees based in general surgery and T&O, some of whom were on the IST programme. The review team also met with the following Trust representatives: • Chief Executive Officer • Medical Director • Clinical Director for Surgery & Training Programme Director (CST/IST) • Foundation Training Programme Directors • Director of Medical Education (and incoming Director of Medical Education) • Medical Education Manager • Surgical Tutor • Educational leads • Educational and clinical supervisors • Guardian of Safe Working Hours

Evidence utilised:	The review team received the following supporting evidence from the Trust in advance of the review: • Trainee Focus Group Reporting Form (T&O) dated 24 September 2020; • Trainee Focus Group Reporting Form (Surgery) dated 19 June 2020; and • Local Education Committee meeting minutes dated 1 November 2019. The review team also utilised evidence from the GMC NTS 2019, Health Education England's (HEE) National Education and Training Survey 2018 and 2019, and the Trust's action plans relating to the training programmes under review.

Review Panel

Role	Job Title / Role
Quality Review Lead	Jo Szram, Deputy Postgraduate Dean for South London, Health Education England
Specialty Expert	John Brecknell, Head of the London Specialty School of Surgery, Health Education England
Foundation School Representative	Jan Welch, Director of South Thames Foundation School, Health Education England
General Practice Representative	Veni Pswarayi, Associate GP Dean for South London, Health Education England
Learner Representative	Dean Malik, Learner Representative
Lay Representative	Sarah-Jane Pluckrose, Lay Representative
HEE Quality Representative	Gemma Berry, Learning Environment Quality Coordinator for South West London, Health Education England
Supportive Role	James Oakley, Quality & Patient Safety Officer for South London, Health Education England

Executive Summary

The review team would like to thank the Trust for accommodating the review.

The review team was pleased to note some examples of good practice within areas of the surgical directorate and in particular, the Surgical Tutor was commended for their dedication to the role of educational lead.

However, several serious concerns were highlighted to the review team, requiring urgent attention by the Trust.

The review team was informed of some patient and learner safety issues relating to a lack of clinical supervision, with junior doctors reportedly making clinical decisions significantly beyond the scope of their competence. The review team also heard that the NHS seven-day services clinical standard for all emergency surgical patients to be seen by a suitable consultant within 14 hours of admission was not being met.

Trainees reported a heavy workload, particularly whilst on-call, with limited access to senior support and minimal or no additional cover for the Ambulatory Surgical Hub (ASH) on these shifts.

A reliable system also needed to be put in place to ensure senior input during ward rounds, including senior review of patients on a daily basis.

The review team heard that a significant proportion of the surgical consultant body were unsupportive of trainees in their daily duties, as well as their educational requirements.

Other areas for improvement included departmental induction, office space and IT access for trauma and orthopaedic (T&O) trainees, rota arrangements, scheduling of formal teaching sessions and workplace training.

Actions have been set for all of the above concerns (outlined in this report), which will be reviewed by HEE as part of the three-monthly action planning timeline.

Review Findings

Not all the Quality Framework standards have been included within the tables below. The standards included are where the quality interventions are expected to have a direct operational impact on the quality of the learning environment. The other standards are still expected to be reviewed for each organisation and will be undertaken through different tools than the Quality Interventions identified within Table 2.1

Identify the review findings for each of the relevant standards below and remove the standards where there is no comment to be made.

Domain 1 - Learning environment and culture

1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive 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 interprofessional learning opportunities.

HEE Standard	HEE Quality Domain 1 - Learning environment and culture	Requirement Reference Number
1.1	**Handover** The review team was informed by the foundation year two (F2) and general practice (GP) trainees based in general surgery and trauma and orthopaedic surgery (T&O) that a general surgery handover meeting took place at 08:00 every weekday. This was attended by the on-call consultant, higher trainee/locally employed doctor (LED) and junior-level trainee ending their night shift, and the junior-level trainee and higher trainee/LED starting the day shift, along with any foundation year one (F1) trainees on-call or for the take specialty. At night, handover meetings were held at 20:00, when the junior-level trainee starting on shift was given a handover by the higher trainee/LED ending their shift. The F2 and GP trainees thought the handover process for T&O was quite good, following some recent improvements. Weekday morning handover was undertaken during a 'trauma meeting' and there was also a 17:00 on-call handover each afternoon. The trainees themselves had recently instituted a new traffic light system for weekend handover, helping to prioritise the most unwell patients, in the absence of a formal weekend handover process. They welcomed a more formal weekend handover process with appropriate senior oversight being established.	Yes, please see S1.1a
1.4	**Appropriate levels of clinical supervision** The F2 and GP trainees told the review team that they found clinical supervision in the surgical teams to be extremely variable and whilst some consultants were very proactive, others lacked interest. The review team heard that until a few months ago, T&O ward rounds were led solely by junior-level trainees, but a higher trainee/LED was now supposed to partake on a daily basis. However, this was reportedly not always the case. Higher trainee/LED attendance for general surgery ward rounds was also said to be inconsistent. The trainees felt that their workload increased when senior supervision on ward rounds was missing. They also reported a lack of forward-planning, coordination and contingency planning around ward rounds, and thought that the higher trainees/LEDs were unsure what was expected of them in this regard. The review team heard that consultants did not join ward rounds if higher trainees/LEDs were not there. The educational and managerial leads also acknowledged that higher trainees/LEDs were occasionally absent from ward rounds and that this needed to be investigated. In contrast, the supervisors thought higher trainees/LEDs attended ward rounds on a daily basis and confirmed this was	Yes, please see S2.2a & S5.1b Yes, please see S1.4a

	built into their timetables. They said there was a 'floating' higher trainee/LED who could cover a ward round if the rostered higher trainee/LED was unable to attend. They said they would want to be made aware if there were any issues in this regard. The review team was informed by the F2 and GP trainees that the on-call T&O higher trainee/LED did not hold a bleep, rendering them uncontactable at times. They were also often scrubbed into theatre during the day (08:00 – 17:00) and unable to offer advice in a timely manner. These factors were said to be challenging for the F2 and GP trainees, particularly when they needed to escalate cases to a more senior clinician. The trainees advised that they were also left to make decisions about admitting or discharging patients on their own. They felt that the delays caused by these scenarios created patient safety issues and inefficiencies in care, as well as contributing to an increased workload at the end of their shift. The F2 and GP trainees found access to clinical supervision particularly challenging out of hours, leading them to feel additional, significant pressure to make unsupervised decisions beyond their clinical competency. They especially felt some reluctance to contact an on-call higher trainee/LED during night shifts for borderline cases, increasing this sense of pressure. They advised that at night-time, not all referrals would be discussed and not all patients would be seen due to a lack of senior-level presence. The educational and managerial leads said that T&O higher trainees/LEDs on-call at night (17:00 – 08:00) were always based in the high-risk Covid-19 zone, segregated from the non-Covid zone. The review team recommended rostering an additional junior-level trainee on-call at night to offer support to the F2 and GP trainees. The review team was concerned to hear that whilst most surgical patients were eventually reviewed by a higher trainee/LED within 12 hours (and no later than 24 hours) of admission, the F2 and GP trainees did not think that all patients were reviewed by a consultant within 14 hours of admission, in keeping with NHS seven-day services clinical standards (standard two). The trainees said that whilst every T&O admission was discussed in a weekday 'trauma meeting', consultants and higher trainees/LEDs did not always partake in ward rounds or see patients in person, although some consultants were reportedly more proactive at seeing patients than others. In contrast, the educational and managerial leads advised that in T&O, consultants conducted a 'hot round' seeing all new admissions with junior-level trainees and that an elective surgery ward round was conducted by a higher trainee/LED and junior-level trainee. They said there was always a consultant on-call for T&O, urology and general surgery respectively, with on-call junior-level doctors also covering each of these specialties, but the junior-level doctors would cross-cover one another if there were more than three patients waiting to be seen in any one area.	Yes, please see S1.4b Yes, please see S1.4c Yes, please see S1.4c Yes, please see recomm-endation S1.4d Yes, please see S1.4e
1.4	**Appropriate levels of educational supervision** The F2 and GP trainees reported some IT issues with the new training portfolio system, which meant they could not document meetings with their supervisors. These issues were being investigated by a portfolio manager but had yet to be resolved. Some of the F2 and GP trainees confirmed that they had undertaken a planning meeting with their educational supervisor (ES) and clinical supervisor	

	(CS) on commencing in post. However, they felt that objective-setting was largely trainee-led and that they had had to be proactive in this regard, in the absence of formal supervision processes. The trainees said that some supervisors were very approachable if they wanted to discuss any educational concerns on an ad hoc basis, but that a greater degree of structure around supervisory meetings would be beneficial. The original proposal of the Improving Surgical Training (IST) programme was for trainees to spend an hour per week with their ESs over the course of a year. The core surgical trainees said this was variable, depending on which ES they were assigned to. For some, regular meetings had been scheduled in advance, whereas for others, initial meetings had taken place and nothing more had been arranged. However, the trainees generally found their ESs to be approachable and the Surgical Tutor (ST) was particularly commended for their investment in training, educational supervision, accessibility and pastoral care. The educational and managerial leads told the review team that there were plans to establish an informal mentorship programme between foundation trainees and anaesthetics trainees, to support their learning.	Yes, please see S1.4f
1.5	**Access to Library and Knowledge Services** The review team heard from the F2 and GP trainees that a room where T&O consultants, locally employed doctors (LEDs) and trainees previously based themselves and worked together as a team had been removed due to a new elective care centre. The trainees said they were now struggling to find an alternative space and there was only one working computer in their clinical area. The supervisors acknowledged the lack of space for trainees and said this issue had been raised at numerous clinical governance meetings, but that management had yet to find a solution.	Yes, please see S1.5a

Domain 2 – Educational governance and leadership
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.

HEE Standard	HEE Quality Domain 2 – Educational governance and leadership	Requirement Reference Number
2.1	**Effective, transparent and clearly understood educational governance systems and processes** The F2 and GP trainees confirmed that they were aware of exception reporting for missed educational opportunities. The educational and managerial leads advised that exception reporting for additional hours worked was not a significant issue in surgery. The review team was told by the Trust's Guardian of Safe Working Hours that the surgical departments were very	

	receptive to exception reports and were keen to address any issues when they arose. The supervisors told the review team that Local Faculty Group (LFG) meetings were held as part of clinical governance consultant meetings and used to develop or review multiple consultant reports (MCRs).	
2.1	**Impact of service design on users** The educational and managerial leads advised that during an internal focus group in October 2019, surgical trainees had raised concerns about workload and rota gaps, and that F2, GP and core surgical trainees found on-call shifts to be particularly busy. The leads also told the review team that in general surgery and urology in particular, there were rota gaps during the initial surge of the Covid-19 pandemic, but these gaps had since been filled and all of the surgical teams were now fully staffed, except for one vacancy in T&O. To meet this need, the Trust had recruited LEDs and Medical Training Initiative (MTI) scheme trainees from Ghana (which had reportedly been a very successful programme for the surgical departments). The F2 and GP trainees told the review team that workload whilst on-call was usually very intense and it was common not to take any breaks during these shifts. From a workload and patient safety perspective in general surgery specifically, the trainees thought that two trainees/LEDs were required (and should have been rostered) to cover the Ambulatory Surgical Hub (ASH) hot clinic and on-call respectively during the day. However, this had rarely been the case in their experience and one junior-level trainee usually covered both with minimal senior support. There was a rota line for ASH, but the trainees reported some ambiguity about whether annual leave could be taken when on this line. The F2 and GP trainees felt that the daytime T&O rota had improved following three iterations in four months. This had been organised by one of the higher trainees/LEDs, who had reportedly worked hard to structure an appropriate balance between educational opportunities and service delivery. Whilst the educational and managerial leads suggested the surgical trainees' workload, particularly on night shifts, was relatively small, the supervisors thought that junior-level trainees were often overburdened. They expressed some concern that the trainees would be burnt out by the end of their placements if they were not offered appropriate support. In light of reported difficulties recruiting junior-level LEDs recently, the supervisors expressed a desire to establish more multi-professional roles within the surgical teams and hoped this would be agreed by Trust management. They said that the use of physician associates (PAs) in some departments at the Trust had helped with efficiency and the delivery of better care for patients in a sustainable way. However, the educational and managerial leads said that across the directorate, a decision had been made to invest in junior doctors to address workload concerns (rather than PAs, for example), although they were exploring the use of surgical assistants in theatre. They said they had tried to find solutions that would not take learning opportunities away from trainees. They also informed the review team that there was a pharmacist based on every surgical ward, trained to issue discharge prescriptions (TTOs), who could help to support and teach junior-level doctors. Because the pharmacy system was paper-light, they thought the administrative burden on trainees was minimal in this regard.	Yes, please see S2.1a Yes, please see S2.1b

	The F2 and GP trainees confirmed that a pharmacist was based on each of the surgical wards, but advised that not all of them were qualified to prescribe and sometimes medications were not checked for several days. TTOs were usually written up by the trainees and screened by the pharmacists, who would highlight any medication errors. Some of the pharmacists would amend prescriptions with verbal permission or a signature from a trainee. However, the trainees did not feel that their workload from TTOs was problematic. The review team heard from the F2 and GP trainees that although some trainees covered trauma calls at night, there were always two advanced trauma life support (ATLS)-trained doctors in the emergency department and anaesthetics team to lead these calls, along with a consultant until midnight. The educational and managerial leads informed the review team that there were no plans to redeploy surgical trainees to critical care departments during a second Covid-19 surge. However, they thought the trainees were now better prepared to care for Covid-positive patients on wards following a critical care induction, and there were plans to hold equipment-focussed practical training sessions to support this.	Yes, please see 2.1c
2.2	**Appropriate systems for raising concerns about education and training** As the Clinical Director for Surgery at the Trust was also the regional Training Programme Director for core surgical training (CST) and IST, the core surgical trainees suggested this created a perceived conflict of interest, particularly when trainees were raising concerns about education and training. The trainees said that if all of the surgical consultants shared the same values as the ST, the Trust would be an exceptional place to train, but unfortunately this was not the case. They reported having to carefully choose who to approach about training issues as they felt that a significant proportion of consultants did not have any interest in education, pastoral care or succession planning. In some cases, the negative behaviour of some consultants had caused emotional upset to the trainees and they felt there were cultural issues within the surgical departments that needed to be addressed so that the training experience could improve. The review team was informed that when some consultants had previously tried to promote a more supportive environment, they had met resistance from other senior members of the surgical teams. The educational and managerial leads and supervisors told the review team that a fortnightly trainee survey had been established, to better understand their needs and concerns. They thought this survey was having a positive impact on the surgical learning environment and feedback from September 2020 suggested improvements had been made in respect to senior support, staffing, educational opportunities and requesting annual and study leave. However, the educational and managerial leads recognised that progress was still to be made and there were some ongoing issues to be addressed, including the delivery of teaching and training for F2 trainees. They advised that the new F2 Training Programme Director had some good ideas for improvement. The supervisors thought that in general, junior-level trainees still did not feel their concerns were being heard. They suggested that educational governance processes needed to be formalised so that trainees were able to	Yes, please see S2.2a & S5.1b

	raise concerns and share feedback more easily. However, trainee feedback was reportedly now being fed into clinical governance consultant meetings.	

Domain 3 – Supporting and empowering learners
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.

HEE Standard	HEE Quality Domain 3 – Supporting and empowering learners	Requirement Reference Number
3.4	**Induction (organisational and placement)** The review team heard that, whilst the F2 and GP trainees received an organisational induction on joining the Trust, they did not all receive a formal departmental induction when they first started in post within the surgical division. In some cases, this did not take place until a couple of weeks later when they had already started on-call night shifts. In contrast, the educational and managerial leads said that newly-inducted trainees were not rostered onto night shifts straight away. The F2 and GP trainees confirmed that they were asked for and provided feedback on their departmental induction, either formally or informally. Some of the trainees felt that the departmental induction was reasonably comprehensive, but that in some cases it could have been better tailored to their level of training. The review team heard that the F2 and GP trainees had been given some confusing information about their rota during induction. Whilst they were initially told that a 'firm-style' rota was in place, this was not implemented until approximately two months later. Furthermore, the trainees reported that there was a lack of clear written guidance around the Trust's policy for accepting patients into the surgical departments and some of the induction handbooks were not detailed enough for new junior-level trainees. Clinical guidelines were reportedly available on the Trust's intranet but the trainees did not find these to be very helpful and they had sought other, more useful guidance themselves.	Yes, please see S3.4a Yes, please see S2.1b
3.2	**Time for learners to complete their assessments as required by the curriculum or professional standards** The F2 and GP trainees thought that the process for arranging sign-off of procedures by consultants and higher trainees/LEDs worked quite well.	
3.3	**Access to study leave** The F2 and GP trainees reported that in T&O, they were supposed to have two hours per week allocated to administration and careers planning but this	

	had been consolidated into one day per month of study leave. This was said to be different for general surgery, but the review team was not told how.	

Domain 4 – Supporting and empowering educators

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 appropriately supported to undertake their roles.

HEE Standard	HEE Quality Domain 4 – Supporting and empowering educators	Requirement Reference Number
4.1	**Access to appropriately funded professional development, training and appraisal for educators** The supervisors told the review team that the Trust's postgraduate education team was supportive and well-resourced, and that regular training sessions were held for ESs.	
4.4	**Appropriate allocated time in educators' job plans to meet educational responsibilities** The supervisors said they generally managed to fulfil their educational responsibilities with the time they were allocated in their job plans (0.25PAs per trainee).	

Domain 5 – Delivering curricula and assessments

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.

HEE Standard	HEE Quality Domain 5 – Developing and implementing curricula and assessments	Requirement Reference Number
5.1	**Placements must enable learners to meet their required learning outcomes** Although the review team heard from the educational and managerial leads that surgical teaching sessions were taking place on a regular basis, the F2 and GP trainees reported an absence of formal, scheduled teaching for general surgery. Whilst educational days were rostered for the general surgery trainees, they did not include structured teaching. In T&O, the trainees told the review team that a teaching fellow in the department had recently implemented rostered educational days (one day every four weeks for F2 trainees) and developed a weekly teaching programme on Fridays. The trainees commended the teaching fellow for their work on improving educational provision and said they had been very proactive in listening and responding to trainees' needs, as reflected in the teaching programme. This sentiment was also shared by the educational and	Yes, please see S5.1a Yes, please see S1.4f

	managerial leads, who thought that the new teaching programme was a very positive step forward. The educational and managerial leads and supervisors also informed the review team that teaching sessions on hand and upper limb conditions were now scheduled solely for GP trainees. The supervisors said that they were already seeing good results from these sessions. However, the educational and managerial leads said that attendance had been poor and they needed to understand why, as it was important trainees attended the training offered to them. They recognised that teaching arrangements had been more challenging recently due to trainees being separated into Covid and non-Covid groups whilst on duty. The review team heard from the F2 and GP trainees that learning opportunities were minimal whilst working on wards and although on-call shifts provided more opportunities to develop practical skills, service delivery often took priority. The trainees felt that any practical skills training they received was usually incidental, rather than being formally planned. They said that some surgical consultants and higher trainees/LEDs were more proactive in this regard than others. It was suggested that formal, rostered practical skills days might be useful. The educational and managerial leads recognised that GP trainees wanted to spend time in clinic and said they tried to give them protected slots each week for this, but that it was challenging to balance these learning opportunities with ensuring appropriate ward cover. The core surgical trainees suggested that the Trust was not sufficiently prepared to meet the objectives of the IST programme. They felt that senior leads in the surgical departments did not seem to be fully aware of the training requirements and initiatives of the programme, or how they were expected to facilitate these. To date, the trainees found it difficult to identify how the training of those on the IST programme was significantly different to those on the standard CST programme. The core surgical trainees reported feeling reasonably content with the amount of time they got to spend in theatres, albeit their learning opportunities and practical experience was somewhat variable depending on the surgical team, rota arrangements, workload and the combination of trainees in theatre at any one time. The trainees told the review team that they generally had to be proactive in seeking or creating suitable learning opportunities for themselves. They also said there was resistance from some senior surgical leads towards establishing theatre timetables for trainees, alongside a general lack of engagement and investment in training and improving skills at core training level. However, the upper gastrointestinal surgery firm had recently established a weekly planning meeting which the trainees said had helped to improve the coordination of theatre activities and recommended this was replicated across all of the surgical teams. The review team also heard from some trainees that they had been given the opportunity to perform procedures under direct consultant supervision and had received teaching during theatre lists. The supervisors also thought that the newly established planning meeting for upper gastrointestinal surgery had brought a number of benefits, including	Yes, please see S5.1b Yes, please see S2.2a and S5.1b

	better staffing of services and more opportunities for trainees to attend theatre. However, the supervisors recognised that trainees on the IST programme had not generally had an optimum learning experience to date, particularly in theatres, due to a lack of understanding by consultants about the aims and objectives of the programme. It was hoped that this would improve through ongoing communication within the surgical teams. The supervisors also acknowledged the support higher trainees offered to more junior trainees. The review team heard from the educational and managerial leads that new theatre lights with built-in cameras (Proximie) had been installed and arrangements were being made with IT to offer trainees the option to observe operations remotely through a new virtual livestreaming platform. It was hoped this would improve their learning opportunities, whilst limiting their exposure to Covid-19 risks. The supervisors informed the review team that core and higher surgical trainees were now taking their Royal College of Surgeons membership examinations later than they had in the past due to delays in meeting their curriculum requirements.	
5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The review team was informed by the F2 and GP trainees that on occasion, they had been pulled from their rostered educational days to cover service provision on the wards. This was largely due to rota gaps, which had been more of an issue in the past than presently. Similarly, educational days were supposed to be rostered for all core surgical trainees, but these were occasionally missing from their rotas. This was of concern to the trainees, due to missed learning opportunities and the potential for not meeting their curriculum requirements.	

Domain 6 – Developing a sustainable workforce

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 of 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.

HEE Standard	HEE Quality Domain 6 – Developing a sustainable workforce	Requirement Reference Number
6.1	**Retention and attrition of learners** Most of the F2 and GP trainees said they would recommend their training posts in general surgery and T&O, but that on-call shifts could be stressful, overwhelming and exhausting. They also expressed concern that if the new, improved rota for T&O were not maintained, their perspective on the learning environment might be different.	Yes, please see S2.1b

Requirements (mandatory)

Any Immediate Mandatory Requirements (IMRs) identified should be identified separately in the appropriate table below. The requirement for any immediate actions will be undertaken prior to the draft Quality Review Report being created and forwarded to the placement provider. The report should identify how the IMR has been implemented in the short term and any longer termed plans. Any failure to meet these immediate requirements and the subsequent escalation of actions to be taken should also be recorded if there is a need to.

- All mandatory requirements should be detailed in this section. The requirement reference should work chronologically throughout the report and link with the right-hand column in the 'Review Findings' section
- Requirements identified should be succinct, SMART and not include the full narrative from the detailed report
- Any Requirements should clearly relate to improved achievement of HEE Domain & Standards by the placement provider

Immediate Mandatory Requirements Given the severity of an Immediate Mandatory Requirement, initial action must be undertaken as required within 5 days and will be monitored by HEE Quality Team. Completion of immediate requirements will be recorded below. Subsequent action to embed and sustain any changes may be required and should also be entered below with relevant timescales		
Requirement Reference number	**Review Findings**	**Required Action, timeline, evidence** **(to be completed within 5 days following review)**
N/A	N/A	N/A
Requirement Reference number	**Progress on immediate actions**	**Required Action, timeline, evidence** **(to be completed within an agreed timeframe)**
N/A	N/A	N/A

Mandatory Requirements The Quality Review Panel will consider which individual or collective findings from the intervention will be added to the Quality Reporting Register, determining the relevant risk score, ISF rating and reflecting the accepted QRR narrative conventions.		
Requirement Reference number	**Review Findings**	**Required Action, timeline, evidence**
S1.1a	The review team heard that trainees had recently instituted a new traffic light system for weekend handover, helping to prioritise the most unwell patients, in the absence of a formal weekend handover process. The review team requests that a more formal weekend handover process with appropriate senior oversight is established. The Trust should consider accommodating some of the useful aspects of the system developed by the trainees.	Please provide a written overview of the new weekend handover process and evidence that this has been discussed with trainees, via Local Faculty Group (LFG) meeting minutes or equivalent. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S1.4a	A reliable system needs to be put in place for a higher trainee/locally employed doctor (LED)-led ward round and prompt senior review of patients on a daily basis. The review team requests that a 'consultant of the week' model be considered by the Trust.	Please provide evidence of a new daily higher trainee/LED-led ward round system, and evidence that a 'consultant of the week' model, or equivalent, is being established across the surgical teams. Trainee feedback from a learner forum, survey or LFG minutes with trainee representative reports should show that any new system is consistent and achieves prompt senior review of patients on a daily basis. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S1.4b	The review team requests that a system is established for alerting consultants when a senior-level doctor is not present on ward round.	Please provide an overview of this alert system for ward rounds and evidence that this has been communicated across the surgical teams, via LFG meeting minutes or equivalent. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.

S1.4c	The review team was informed of some patient and learner safety concerns in relation to a lack of clinical supervision. Junior-level trainees were reportedly making clinical decisions significantly beyond the scope of their competence on a regular basis. Furthermore, whilst the Trust considered night-time workload to be relatively light, this was not the experience reported by trainees, who found it to be of high intensity and stress.	Please provide a written plan (referencing rota arrangements and on-call higher trainee/LED bleep arrangements) outlining how clinical supervision processes are being revised to ensure junior-level trainees have access to senior-level support at all times during the day and night across all surgical teams. Please also provide updated trainee feedback on these changes to clinical supervision, and levels of stress, via LFG meeting minutes or equivalent. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S1.4e	In keeping with the NHS seven-day services clinical standards (standard two), all emergency surgical patients should be seen by a suitable consultant within 14 hours of admission. The review team heard that this was not being delivered. Trainees should not be solely responsible for reviewing these patients.	Please provide written evidence demonstrating how all emergency surgical patients are being seen by a consultant within 14 hours of admission, and evidence that night-time cover of surgical services is being reviewed, including consideration to an extended surgical team and/or 'Hospital at Night' system. This evidence should include the pathway/process, and audit data to show that the target is being met, as well as trainee feedback. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S1.4f	The review team heard examples of good practice within areas of the directorate and advises that sharing this across the surgical specialties would benefit training more widely.	Please provide evidence that effective processes and good practice are being discussed and shared (with involvement from trainees) across surgical teams, via LFG meeting minutes or equivalent. The Trust should consider establishing a regular extended surgical LFG to focus trainers, leads and trainees on improving surgical training across all specialties. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S1.5a	The office space and IT access for trauma and orthopaedic (T&O) trainees was felt to be inadequate both by trainees and supervisors, and whilst the review team was told that the Trust was aware of the problem and seeking a solution, this matter needs to take high priority.	Please provide confirmation of the office space and IT access found for T&O trainees and provide trainee feedback on these facilities, via LFG meeting minutes or equivalent. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S2.1a	The trainees reported a very heavy workload during daytime on-call shifts, with minimal or no additional cover for the Ambulatory Surgical Hub (ASH). Access to senior support was also reportedly very limited during these shifts.	Please provide written evidence in the form of rota arrangements or similar, to show that additional cover is being put in place for the ASH (at least two doctors rostered at any one time) and evidence to demonstrate how senior-level support is being made available to trainees during daytime on-call shifts, including bleep arrangements for the on-call higher trainee/LED,

		across all surgical teams. Trainee feedback on the system is also required. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S2.1b	Whilst the trainees were reportedly happy with their current rota arrangements, they expressed concern that the rota had changed several times in the last few months, including on the day of induction. The review team asks that the Trust reviews rota practice, with input from the Guardian of Safe Working Hours (GOSWH).	Please provide evidence that surgical rota arrangements have been reviewed in conjunction with Trust management and the GOSWH, via meeting minutes or equivalent, focusing on timelines for rotas being issued, and any changes. Trainee feedback on this matter is required. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S2.1c	There is a lack of clarity over arrangements for discharge prescriptions (TTOs) and the scope of practice of the current pharmacy establishment on the surgical wards in this regard.	Please provide an overview of the pharmacy establishment on the surgical wards, including the proportion of prescribing pharmacists and a process document outlining arrangements for TTOs, demonstrating how pharmacy workforce will support this work on a regular basis. Trainee feedback on this matter is required. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S2.2a	The review team heard that a significant proportion of the consultant body were unsupportive of trainees in their daily duties, as well as their educational requirements. This cultural issue requires urgent attention by the Trust.	Please provide evidence that these cultural issues within education are being addressed through discussion and action planning with the consultant body by the Director of Medical Education and Medical Director (or Associate Medical Director). Please provide evidence that a meeting has been arranged for trainees with the Trust's Freedom to Speak Up Guardian and that trainee attendance at the meeting has been encouraged and facilitated. Trainee feedback to demonstrate improvement is also required. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S3.4a	Departmental inductions require significant improvement. Induction must take place before trainees start clinical duties (including night shifts), useful and updated written information must be provided and training is essential in advance of minimally supervised delivery of any practical skills (for example, aspiration of a joint effusion) being required.	Please provide copies of departmental induction programmes for the surgical teams (for all training grades), including training sessions, and evidence of written guidance available to trainees upon starting in post, such as induction booklets and clinical guidance. Trainee feedback on timely and quality induction is required. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S5.1a	Whilst the review team was pleased to hear that members of the surgical departments were keen to teach and deliver sessions, consistent scheduling and the ability for trainees to attend on a regular basis was not evident. In particular, whilst	Please provide a schedule of teaching sessions for all surgical specialties and training grades, and demonstrate how these align with trainees' rota arrangements to enable attendance. Trainee feedback on this matter is also required.

	formal T&O teaching appeared to be taking place, teaching for other surgical specialties had not yet been implemented.	Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.
S5.1b	The trainees reported that there was significant variability between consultants in terms of their willingness to provide supervision and workplace training. The review team was concerned to hear that trainees who had previously gained competencies were not supported to maintain or develop these by some consultants.	Please provide evidence that regular educational and clinical supervision meetings are taking place between consultants and trainees and that processes are in place to facilitate and monitor trainees' workplace training and competencies. Please also provide evidence that quality of supervision and workplace training is being discussed at LFG meetings or equivalent. Trainee feedback on this matter is also required. Please submit this evidence by 1 March 2021, in line with HEE's action plan timeline.

Recommendations

Recommendations are not mandatory, and they would not be expected to be included within any requirements for the placement provider in terms of action plans or timeframe. It may however be useful to raise them at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Recommendation	
Related Domain(s) & Standard(s)	**Recommendation**
S1.4d	The review team recommends rostering an additional junior-level trainee on-call at night to offer support to the foundation year two (F2) and GP trainees.

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the HEE Quality representatives, enable the standards within the Quality Framework to be more effectively delivered or help make a difference or improvement to the learning environment being reviewed. Examples of good practice may be worthy of wider dissemination

Learning environment / Prof. group / Dept. / Team	Good practice	Related Domain(s) & Standard(s)
Core Surgical Training (CST) / Foundation (F2) Surgery / GP Surgery	The Surgical Tutor was commended by trainees and supervisors for their dedication to the role of educational lead within the directorate, and was described as supportive, knowledgeable about current educational practice and heavily engaged with training. The review team advised that the Surgical Tutor's vision of change for improvement should be supported by the Trust's leadership team.	2 & 4

Report sign off

Outcome report completed by *(name)***:**	Gemma Berry
Review Lead signature:	Dr Jo Szram, Deputy Postgraduate Dean, South London
Date signed:	15 December 2020

HEE authorised signature:	Prof Geeta Menon, Postgraduate Dean, South London
Date signed:	15 December 2020

Date final report submitted to organisation:	15 December 2020

What happens next:

Any requirements generated during this review will be recorded and monitored following the usual HEE Quality Assurance processes.
As part of our intention to development a consistent approach to the management of quality across England, Quality Reports will increasingly be published and where that is the case, these can be found on (web link)Information from quality reports will be shared with other System Partners such as Regulators and Quality Surveillance Groups