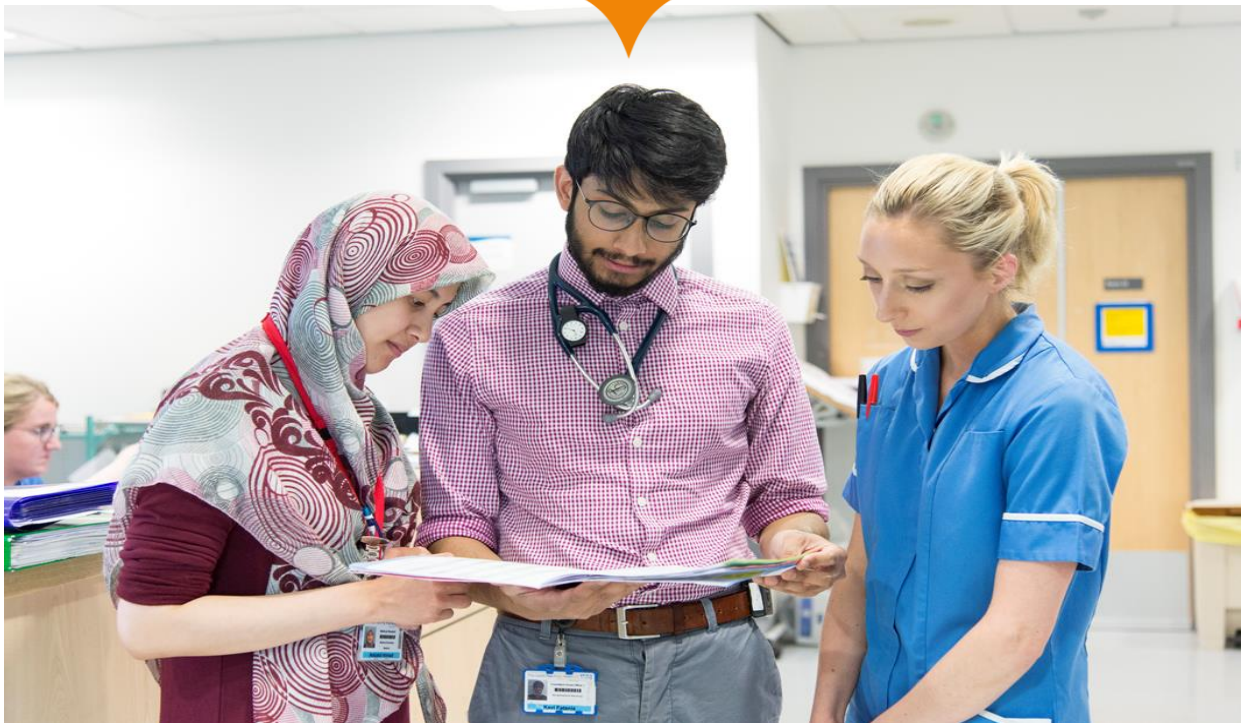


HEE Quality Interventions Review Report

**Royal Free London NHS Foundation Trust
Maternity Services
Multiprofessional Learner and Educator Review**



HEE London

1 July 2020

Final Report 20 August 2021

Review Overview

<p>Background to the review:</p>	<p>This follow-up review was scheduled for Maternity Services at Royal Free Hospital, with services rated as inadequate by the Care Quality Commission at an inspection on 27 October 2020. There were concerns raised around the leadership and incident investigations with missed opportunities for learning.</p> <p>HEE conducted a quality review in February 2020 which reported issues with the impact of the gynaecology 'hot week' on-call consultant arrangement, escalation pathways and allocation of theatre lists. There were two remaining actions open from this review requiring the Trust to ensure that Foundation, GP and higher specialty trainee work schedules are designed to include the requisite clinical opportunities (theatre lists and clinics) needed to meet their curriculum criteria.</p> <p>The National Education and Training Survey (NETS) also found some concerns with Midwifery at the Royal Free, with the survey reporting a negative outlier for Bullying and Undermining at Royal Free London NHS Foundation Trust.</p>
<p>Subject of the review (e.g. programme, specialty, level of training, healthcare learner group)</p>	<p>The subjects of this review included the following learners within the Maternity Services department:</p> <ul style="list-style-type: none"> - Obstetrics and Gynaecology specialty trainees from Royal Free Hospital - Midwifery learners from Barnet Hospital and Royal Free Hospital - Sonographer learners from Barnet Hospital and Royal Free Hospital - Physiotherapy learners from Barnet Hospital and Royal Free Hospital

<p>Who we met with:</p>	<p>The review team met with the following:</p> <p>Trust representatives:</p> <ul style="list-style-type: none"> - Directors of Medical Education (x2- job share) - Head of Quality PGME - Head of Midwifery (Royal Free Hospital) - Obstetrics Consultant - Head of Education and Development for Allied Health Professionals - Head of Education for Nursing and Midwifery - Clinical Practice Facilitator - Midwives (Barnet Hospital) - Clinical Director for Obstetrics and Gynaecology (Royal Free Hospital) - Consultant Midwife - Medical Education Manager - Guardian of Safe Working (Royal Free Hospital) - Clinical Practice Facilitator - Head of Midwifery (Barnet Hospital) - Consultant Lead for Midwifery Education (Royal Free Hospital) <p>Obstetrics and Gynaecology trainees:</p> <ul style="list-style-type: none"> - The review team met with twelve obstetrics and gynaecology specialty trainees from grade F1-ST7 (including Foundation and GP trainees) <p>Healthcare learners:</p> <ul style="list-style-type: none"> - The review team met with eleven healthcare learners from Midwifery, Sonography and Physiotherapy programmes <p>Obstetrics and Gynaecology educators:</p> <ul style="list-style-type: none"> - The review team met with eight obstetrics and gynaecology Clinical Supervisors <p>Healthcare learner Educators:</p> <ul style="list-style-type: none"> - The review team met with thirteen Educators supporting Midwifery, Sonographer and Physiotherapy learners
<p>Evidence utilised:</p>	<p>The following evidence was submitted by the Trust in preparation for this review:</p> <ul style="list-style-type: none"> - OG LFG Minutes 23 Apr 2021 - RF Obs Gynae F2 ST1-2 GPVTS Aug 19 – Rota Summary - RF Obs Gynae ST3+ Aug 20 – Rota Summary

Review Panel

Role	Name / Job Title / Role
Quality Review Lead	Dr Bhanu Williams Deputy Postgraduate Dean
HEE Head of Specialty School of Obstetrics and Gynaecology	Dr Greg Ward Head of School for Obstetrics and Gynaecology
HEE Deputy Head of Specialty School of Obstetrics and Gynaecology	Dr Sonji Clarke Deputy Head of School for Obstetrics and Gynaecology
HEE Regional Head of Nursing and Midwifery	Nichole McIntosh Regional Head of Nursing and Midwifery, London
Workforce Transformation Lead	Caroline Ward Workforce Transformation Lead (Clinical)
External Specialty Expert	Dr Claire Homeyard Consultant Midwife
HEE Foundation Head of School	Dr Keren Davies Foundation Head of School
Lay Representative	Robert Hawker Lay Representative
HEE Quality Representative	Nicole Lallaway Learning Environment Quality Coordinator
Supporting roles	Aishah Mojadady Quality, Patient Safety and Commissioning Administrator
Supporting roles	Ummama Sheikh Quality, Patient Safety and Commissioning Officer

Executive summary

This multiprofessional Quality Review was organised due to the recent CQC rating of Maternity Services as 'inadequate' as well as poor performance in the National Education and Training Survey (NETS) in November 2020 for Midwifery learners. The learner groups in scope for this review were O&G trainees at Royal Free Hospital (higher specialty, Foundation and GP), and Midwifery, Sonographer and Physiotherapy learners from both Barnet Hospital and Royal Free Hospital.

The review team were pleased to hear that half of the Clinical Supervisors offered excellent supervision to O&G trainees, and that midwifery, sonography and physiotherapy learners were well supported by their supervisors. However, the following areas of concern were raised at the review:

- Lack of consistent named clinical supervision for higher specialty and foundation trainees in clinics.
- Lack of consultant-led ward rounds twice a day on the labour ward.
- Half of the clinical supervisors were described as unsupportive and unapproachable for O&G trainees, with two named instances of extreme difficulty in accessing consultant on-call support.
- There was a reported conflict between some consultants which had resulted in delayed decision making and patient care.
- There were reported instances of microaggressions and racism by both specific consultants and midwives working out of hours.
- It was reported there were insufficient gynaecology operations and deliveries at Royal Free Hospital for trainees at ST3-5 to obtain adequate curriculum coverage.
- Midwifery learners reported difficulty meeting with their practice assessors to sign off their competencies.

The HEE Review team issued three Immediate Mandatory Requirements (IMRs), as detailed on page 7-8.

Review findings

The findings detailed in the sections below should be referenced to the quality domains and standards set-out towards the end of this template. Specifically, mandatory requirements should be explicitly linked to quality standards. Not all of HEE's domains and standards have been included, only those that have a direct operational impact on the quality of the clinical learning environment, which a quality review will be most likely to identify (although this does not preclude other standards outlined in the Quality Framework being subject to review, comment and requirements where relevant).

Mandatory requirements

Mandatory requirements and Immediate Mandatory Requirements (IMRs) should be identified as set out below. IMRs are likely to require action 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 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
OG1.4a	The review team were concerned to hear of a lack of consistent immediate named consultant supervision for higher specialty trainees in clinics.	There must be a named consultant for every clinic where the trainee can get direct and immediate advice for patient care.
Requirement Reference number	Progress on immediate actions	Required Action, timeline, evidence
OG1.4a	<p>1. There is a named consultant for every clinic, and this is highlighted on the rota. There were two consultants who shielded for the whole year during the pandemic and whose clinics were conducted remotely during this period. Both consultants are now doing face to face clinics.</p> <p>2. Following issues regarding reduction of clinics when consultants are on leave, all clinics will now be cancelled when the consultant is on leave and no juniors will be allocated to the clinic. This will be implemented from 19th July 2021.</p> <p>3. Juniors will be encouraged to raise any concerns regarding consultants not being present /coming late/leaving early without prior notice or arrangements.</p>	
Requirement Reference number	Review Findings	Required Action, timeline, evidence
OG1.4b	The review team were concerned to hear of instances of Foundation trainees undertaking outpatient clinics without consultant supervision. Foundation trainees reported that they found a registrar to support them in the outpatient clinic, however the registrar was covering another busy clinic at the time.	Foundation trainees must not undertake outpatient clinics without direct immediate supervision.
Requirement Reference number	Progress on immediate actions	Required Action, timeline, evidence
OG1.4b	This was a single incident which occurred due to a rota error. F2 trainees are always supernumerary in the clinic and will not be allocated to a clinic without a named consultant. This will be included in the local induction and F2s will be asked to immediately escalate to Trust	

	Education Lead/College Tutor, Service Line Lead for Obstetrics or Clinical Director for Obstetrics and Gynaecology should they find themselves in a clinic unsupervised. Additionally, this will be kept under review at the monthly foundation board with specific feedback request from the O&G F2s.	
Requirement Reference number	Review Findings	Required Action, timeline, evidence
OG1.4c	The review team were concerned to hear that trainees did not always have access to consultant ward rounds twice a day on the labour ward. This was despite national guidance from the Ockenden report stating the requirement for in person consultant-led ward rounds twice a day.	Trainees must have access to in person consultant ward rounds twice daily on the labour ward in accordance with national guidance.
Requirement Reference number	Progress on immediate actions	Required Action, timeline, evidence
OG1.4c	The labour ward rounds are happening twice but the second round is around 6-7 pm with the day team of junior doctors. The plan is to have the second ward round with the night team. The second ward round will be straight after the evening handover. Handover starts at 20.00 and the handover plus ward round is until 21.00 Monday-Friday and 20.00-21.30 Saturday & Sunday. Arrangements have been made for this to be implemented from week commencing 19th July 2021 and formalised in job plans from September 2021.	

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
OG1.2a	The review team heard that while 50% of clinical supervisors (CS) were approachable and supportive, the remaining 50% of CSs did not exhibit the same positive attitude to teaching with incidents of microaggressions and racism within the department. The review team also heard of conflict between consultants which was	The Trust is required to work with the clinical supervisors to foster a positive working culture within the O&G department, where trainees feel supported by all of the consultants. Please demonstrate any work undertaken to improve the culture of the department by the next QMP reporting deadline.

	discussed inappropriately with or in the presence of trainees.	
OG1.2b	The review team heard from Foundation trainees that there were instances of microaggressions by some of the midwives working out of hours. It was felt that this hindered effective communication between disciplines and could negatively impact on patient safety.	The Trust is required to work with the midwifery members of staff to improve the culture of the department when working out of hours. Please demonstrate any work undertaken to improve the culture by the next QMP reporting deadline.
OG1.2c	Due to conflict between some consultants, O&G trainees reported instances whereby decision making on the ward was delayed as cases were deferred to other consultants, which could impact on patient safety.	The Trust is required to ensure that conflict between consultants does not lead to deferred management of patient care and decision making within the department. Please demonstrate any work undertaken to resolve conflict by the next QMP reporting deadline.
OG5.1	The review team found that there were insufficient gynaecology operations and deliveries at the Royal Free site for trainees at grade ST3-ST5 to obtain adequate curriculum coverage.	The Trust is required to urgently look at creating 6 monthly rotations between Royal Free Hospital and Barnet Hospital to ensure that junior trainees get adequate coverage for their curriculum. Please submit evidence in support of this action by the next QMP reporting deadline.
OG4.4	Midwifery learners reported that it was sometimes difficult to meet with their Practice Assessors to sign off their competencies. It was felt that this hindered opportunity to provide valuable feedback and gauge the learners' comprehension of the knowledge and skills acquired.	The Trust is required to ensure that Practice Assessors have protected time in their rosters to meet with midwifery learners to review and sign off their competencies. Please submit example rosters demonstrating that this is in place by the next QMP reporting deadline.

Recommendations

Recommendations are not mandatory but intended to be helpful, 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
OG2.1	The Trust is recommended to ensure all members of the multidisciplinary team within the maternity department know who the Safety Champions are at the Trust, including the roles and responsibilities of the nominated champion.

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the Quality Review Team, 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)

HEE Quality Standards and Domains for Quality Reviews

Domain 1 - Learning environment and culture		
<p>1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.</p> <p>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.</p> <p>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).</p> <p>1.4. There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.</p> <p>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.</p> <p>1.6. The learning environment promotes interprofessional learning opportunities.</p>		
HEE Standard	HEE Quality Domain 1 - Learning Environment & Culture	Requirement Reference Number
1.2	<p>Bullying and undermining</p> <p>Obstetrics and Gynaecology Trainees</p> <p>The review team heard from Trust management that some issues around bullying for the obstetrics and gynaecology (O&G) trainees were raised in the Local Faculty Group (LFG). The Trust reported that they conducted a 360-degree feedback survey for each of the consultants and that overall feedback was reported as positive. The review team heard that there was some negative feedback provided, and that this was provided to the Clinical Director to feedback to the individual supervisor. The Trust acknowledged that there were some negative aspects that required improvement.</p> <p>The O&G trainees reported that following on from the 360-degree feedback exercise, they had not noticed any positive change in terms of support or clinical supervision. For example, following the feedback exercise, they were disappointed to witness some consultants publicly undermining registrars during handover.</p> <p>The review team fed back to the CSs that trainees felt the 360-degree feedback did not produce any significant changes to consultant support and behaviour. The CSs reported that feedback had been given to the consultants and that repeat anonymous 360 feedback could be completed in 6-12 months' time to provide an opportunity for more regular, anonymous feedback on performance. The review team heard that the department planned on conducting a training session on behavioural issues and racism for all of the consultant body within three months from the date of this review, and that this would also be opened to include midwifery colleagues as well.</p> <p>The review team heard from the O&G trainees at Royal Free Hospital that there was a discord among the consultant body which was having a negative impact on the culture of the O&G department. Trainees reported that there were two different groups of consultants; the first group was made up of excellent consultants who were approachable, supportive, and willing to teach the trainees. The second group of consultants reportedly did not have the same attitude to teaching, with incidents of undermining, microaggressions and racism within the department. The trainees reported that this split among the consultant body was 50/50.</p>	Yes, please see OG1.2a

	<p>The review team heard that the microaggressions and evidence of racism was exhibited by a particular consultant and that experiences were not limited to O&G trainees, but also involved patients and other members of the multidisciplinary team. Trainees reported that the consultant in question often mixed-up people of similar ethnicity and stated they could not understand what someone said due to their accent, and that this was used as an excuse for miscommunication. The review team also heard of instances whereby patients in clinic requested to move to a different clinic due to interactions with certain consultants, which caused the second clinic to be busy and overbooked.</p> <p>Some trainees witnessed negative interactions between midwifery co-ordinators and trainees. Some midwives, who were described as predominantly only ever working out of hours, had questioned trainees on their religion and in one instance stated that a trainee supported a midwife because they were the same religion. These interactions hindered communication between the wider multidisciplinary team which could have a detrimental impact on patient safety within the department.</p> <p>The review team heard from foundation trainees that there was a small group of the midwifery team at night who made them feel uncomfortable. Trainees reported that it was common for them to ask members of the midwifery multidisciplinary team to do things and they would not be done, leaving foundation trainees to chase completion of tasks. The review team also heard that foundation trainees felt pulled from all different areas for work by their midwifery colleagues who demonstrated little compassion for the workload put upon the trainees. This also included reports of midwifery colleagues telling patients that the foundation trainees were neglecting their care which made it difficult to build a rapport with the patients.</p> <p>The O&G trainees reported instances of conflicts and personal problems between consultants being shared either with or in front of trainees in an unprofessional manner. Due to the conflict between some of the consultants on the ward, there were also reported instances of delayed decision making as cases were deferred to alternative consultants rather than the ones immediately available. An example of this included delayed management plan of an ectopic pregnancy which was felt could have a detrimental impact on patient safety.</p> <p>Healthcare Learners</p> <p>The review team heard that neither the midwifery learners, sonographer learners nor the physiotherapy learners had experienced or witnessed any bullying and undermining while on placement at both the Royal Free Hospital and Barnet Hospital.</p>	<p>Yes, please see OG1.2b</p> <p>Yes, please see OG1.2c</p>
1.4	<p>Appropriate levels of Clinical Supervision</p> <p>Obstetrics and Gynaecology Trainees</p> <p>The review team heard that some of the O&G trainees were concerned about patient safety when clinics were left unsupervised and when some consultants did not turn up to clinic when asked by trainees for support. The review team heard of two instances in a six-month period reported by trainees at Royal Free Hospital whereby trainees had extreme difficulty in accessing consultant on-call support. These instances both involved a trainee contacting the consultant on-call overnight and they either received no response or the consultant reportedly refused to come in and provide support to the trainee.</p>	<p>Yes, please see OG1.4a</p>

	<p>The midwifery learners felt that the midwives they worked with exhibited professional qualities, including effective communication with patients and colleagues, were excellent at upholding standards and set a positive, professional working example for the midwifery learners to learn from. The review team heard that throughout the pandemic, team morale was high and that this provided a positive working environment for the learners.</p> <p>The review team heard that physiotherapy learners received a good level of clinical supervision, and that there was a good balance between being protected and having the autonomy to do things by themselves.</p> <p>The review team heard that the sonographer learners felt well supported by their supervisors, and that if their supervisors was off sick or on annual leave, they would ensure that the learners had another named member of the team to work with. The sonographer learners felt they were able to ask questions to their supervisors if they had any concerns or difficulties and were supported to take on independent work with appropriate support.</p>	
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Domain 2 – Educational governance and leadership		
<p>2.1. The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.</p> <p>2.2. The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.</p> <p>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.</p> <p>2.4. Education and training opportunities are based on principles of equality and diversity.</p> <p>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.</p>		
HEE Standard	HEE Quality Domain 2 – Educational Governance and Leadership	Requirement Reference Number
2.1	<p>Effective, transparent and clearly understood educational governance systems and processes</p> <p>Obstetrics and Gynaecology Trainees</p> <p>The review team heard that following the maternal death, the Trust brought in a team called Safety Incident Support our Staff (SISOS) that provided ongoing support to members of staff, either individually or as a group. The review team also heard from the Trust managerial leads that trainees were able to meet with their educational and clinical supervisors for support and had a named consultant to provide pastoral support if trainees found themselves in a situation where things went wrong. It was also reported that learning was disseminated to trainees through Tuesday morning teaching sessions, and on Friday mornings there were informal catchups attended by trainees and consultants. This was where trainees and consultants could discuss any opportunities coming up within the department and any potential difficult cases. The managerial leads also listed other forums for disseminating information such as the monthly risk-management meeting, monthly briefings, updates to electronic records and guidelines, risk letters and bi-monthly governance meetings where major incidents and learning were discussed.</p>	

	<p>The review team also heard from Trust leads that SISOS was offered to midwifery learners for support, as well as access to women's health counselling and a 'deep debrief' to support staff and learners from professional midwifery advocates (PMA). The midwifery leads also highlighted that learning was shared in briefings to look at updated guidelines, updates from Serious Incidents, guidelines newsletter, risky business newsletter and clinical practice facilitators (CPF) ensured that learners have access to everything required.</p> <p>The review team were disappointed to hear that following the publication of the Ockenden report at the end of 2020, the O&G trainees did not know who the safety champions were at the Trust, nor did they know the purpose of a safety champion.</p> <p>The O&G trainees reported that following the maternal death in 2020, there was lots of teaching and dissemination of guidelines to share learning throughout the department.</p> <p>The Trust's Managerial leads provided an update on the previous Quality Review's issue around the gynaecology 'hot-week' and noted that they had reworked the structure as it was now only covered by people confident to do so. The Trust also acknowledged that gynaecology training was an issue. The review team heard that there were now extra clinics open to trainees, with the rota run by senior specialty trainees in a bid to maximise training opportunities. However, the review team heard that it was difficult for the Trust to allocate GP trainees to clinics as they required, and they were in the process of improving this as they had increased 1 in 7 to 1 in 8 Senior House Officers (SHO).</p> <p>Healthcare Learners</p> <p>The review team heard from the midwifery learners that following on from the recent CQC report, everything was documented on the Electronic Patient Record (EPR) system. The review team heard that learners were encouraged to prioritise submitting updates on the system following CQC advice. Learners noted that if observations were out of the normal range, then they were encouraged to escalate immediately. The midwifery learners also reported a huge change whereby the Trust website offered more than fifty different language translations to provide information to expectant mothers. This included the interpretation service 'the big word' where patients could highlight text and have it read aloud. The review team also heard that learners were sent regular updates by email and 'risky business' newsletter and were invited to maternity briefings to keep informed on the latest updates in maternity.</p>	Yes, please see OG2.1
2.2	<p>Appropriate systems for raising concerns about education and training</p> <p>Midwifery learners reported that they felt confident to raise any concerns with the midwives or their Clinical Practice Facilitator (CPF), and that they felt well supported to do so. The review team also heard that they were provided with an escalation flowchart on how to escalate concerns, which demonstrated learners could speak to their supervisors in the first instance and follow up with the CPF if necessary. The Midwifery learners also reported that they were fully aware of Trust mechanisms such as Freedom to Speak Up Guardian and the Trust Whistleblowing policy.</p>	

Domain 3 – Supporting and empowering learners		
<p>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.</p> <p>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.</p> <p>3.3. Learners feel they are valued members of the healthcare team within which they are placed.</p> <p>3.4. Learners receive an appropriate and timely induction into the learning environment.</p> <p>3.5. Learners understand their role and the context of their placement in relation to care pathways and patient journeys.</p>		
HEE Standard	HEE Quality Domain 3 – Supporting and empowering learners	Requirement Reference Number
3.4	<p>Induction (organisational and placement)</p> <p>Obstetrics and Gynaecology Trainees</p> <p>The review team heard that trainees in O&G at Royal Free Hospital all received their induction at the start of their placement, and there was a consensus that induction covered everything required for their placements.</p> <p>Healthcare Learners</p> <p>The review team heard that the midwifery learners all had a detailed induction in the first week when in the first year of their training. The learners reported that they were given an orientation of all clinical areas within the maternity department and some learners reported that a second year and third year midwifery learner attended their orientation to provide additional support. The review team heard that midwifery learners all received detailed orientation packs that they could refer back to when needed. While all learners reported that induction was helpful, the review team also heard that it would be beneficial for learners to have a refresher when they join the labour ward in the second year of their placement.</p>	
3.2	<p>Time for learners to complete their assessments as required by the curriculum or professional standards</p> <p>Foundation trainees in O&G reported that they were able to have their workplace-based assessments signed off by their supervisors.</p>	

Domain 4 – Supporting and empowering educators		
<p>4.1. Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.</p> <p>4.2. Educators are familiar with the curricula of the learners they are educating.</p> <p>4.3. Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.</p> <p>4.4. Formally recognised educators are appropriately supported to undertake their roles.</p>		
HEE Standard	HEE Quality Domain 4 – Supporting and empowering educators	Requirement Reference Number
4.4	Appropriate allocated time in educators job plans to meet educational responsibilities	

	<p>The review team heard that midwifery learners found it difficult to meet with their Practice Assessors (PA) to sign off their competencies throughout their placements. It was felt that this was due to how busy the wards were and a lack of allocated time in the PAs job plans to sign off competencies. The review team heard of instances where some learners had to go into the ward in the evening to discuss their workbook with their PA. It was felt that this hindered valuable opportunities to provide constructive feedback and gauge the midwifery learner's comprehension of the knowledge and skills acquired on the placement.</p> <p>The Clinical Practice Facilitators (CPF) acknowledged that the wards were busy and that this impacted on the midwifery learner's ability to have competencies signed off during working hours. The CPFs reported that learners were informed of where their PAs were working and were advised to call the ward to access their PA as not all midwives were working at desks during the day to read emails. The CPFs reported that PAs do not have protected time to sign off competencies at the moment. Some of the PAs reported that a workaround was to ask midwifery learners to come to the ward early in the morning when it was less busy. It was also reported that during orientation, they would discuss the best time for learners to meet with the PA to get their competencies signed off.</p>	Yes, please see OG4.4
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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	<p>Placements must enable learners to meet their required learning outcomes</p> <p>Obstetrics and Gynaecology Trainees</p> <p>The review team heard from O&G trainees that there were insufficient gynaecology operations and deliveries at Royal Free Hospital for trainees at grade ST3-5 to obtain adequate curriculum coverage. The review team heard that the Royal Free Hospital provided appropriate experience for ST6-7 and that teaching was consultant-led and positive. However, it was reported that for ST3-5 trainees, the volume of cases was not enough for trainees to receive adequate experience to cover everything required in the curriculum. The review team heard that junior trainees felt unprepared to step up to a senior registrar rota, and some reported that they had not gained any new skills at Royal Free Hospital than they had already achieved as an ST3 at a different site.</p> <p>Healthcare Learners</p> <p>The midwifery programme leads reported that due to the covid-19 pandemic they were unable to go to clinical areas to meet with learners, and that face-to-face meetings were replaced with virtual calls. It was noted that this was positive as they were able to meet with more learners in a session, and that</p>	Yes, please see OG5.1

	<p>this was something that the programme leads from North Middlesex University and University of Hertfordshire wanted to take forward more permanently. It was felt that a blended model of in-person and virtual teaching would be taken forward once possible. Despite the difficulty of the past year, it was reported that relationships with the Trust was good and that learners found it a supportive environment.</p> <p>The review team heard that midwifery learners were encouraged to attend additional training opportunities following publication of the Ockenden report and the latest CQC report. These included upskilling to interpret cardiotocographs (CTG) for fetal monitoring and neonatal resuscitation.</p> <p>The review team heard that the fetal monitoring lead conducted fetal monitoring teachings on Thursdays where all midwifery learners were invited to attend. It was reported that up to eight midwifery learners were able to attend in person and the session was presented virtually for all other learners as well. It was also reported that there was a monthly fetal monitoring newsletter sent to all midwives and midwifery learners. The fetal monitoring lead was reportedly accessible to all learners and online learning modules were often recommended to learners for continued development.</p> <p>The review team heard from the sonographer learner's supervisors that the covid-19 pandemic impacted on teaching as it was now delivered virtually. The supervisors reported that they felt the sonographer learners were more isolated due to the small numbers of learners and that this impacted on their clinical practice as academic and clinical learning were linked closely together. On the other hand, the review team heard it was positive that lists for ultrasound had been shortened, which meant that learners were able to spend 30 minutes with patients and therefore extended their learning.</p>	
5.1	<p>Appropriate balance between providing services and accessing educational and training opportunities</p> <p>The review team heard that the midwifery learners felt that their supernumerary status was respected while working at the Trust, and that they were able to feel like students learning on the job. The midwifery learners reported that their workload increased as they progressed through their training, and that expectations of their capabilities and responsibilities were increasing each year as appropriate.</p>	

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	<p>Retention and attrition of learners</p> <p>Obstetrics and Gynaecology Trainees</p> <p>The majority of O&G trainees agreed that they would recommend Royal Free Hospital as a place to train for higher specialty trainees ST6 and above and reported that they would not recommend their placement for more junior trainees at grades ST3-5. The review team heard this was due to lack of gynaecology operating and lack of adequate curriculum coverage available for junior trainees at the site. Trainees also reported that they were undecided on whether they would be comfortable with their friends and family being treated at Royal Free Hospital and stated that would depend on which consultant they had.</p> <p>The review team heard that the Foundation trainees and the General Practice trainees at Royal Free Hospital would all recommend the site as a place to train.</p> <p>Healthcare Learners</p> <p>The midwifery learners reported that they would recommend their placement to colleagues as they felt well supported and felt that the Trust offered a conducive learning environment. They also reported that they would be comfortable with their family and friends being treated at the Trust.</p> <p>The review team heard that the sonographer learners and the physiotherapy learners would recommend their placement to colleagues for training and would be comfortable with their family and friends being treated at the Trust.</p>	

Report sign off

Quality Review Report completed by <i>(name(s) / role(s)):</i>	Nicole Lallaway Learning Environment Quality Coordinator
Review Lead name and signature:	Dr Bhanu Williams Deputy Postgraduate Dean for North London
Date signed:	03/08/2021

HEE authorised signature:	Dr Gary Wares Postgraduate Dean for North London
Date signed:	20/08/2021

Date final report submitted to organisation:	20/08/2021
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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 develop 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 HEE's national website. Information from quality reports will usually be shared with other System Partners such as Regulators and Quality Surveillance Groups