Health Education England

HEE Quality Interventions Review Report

London North West University Healthcare NHS Trust (Northwick Park Hospital)
Obstetrics and Gynaecology
Learner and Educator Review

London – North West London
Date of Review: 17 March 2022
Date of Final Report: 19 May 2022

Review Overview

Background to the review

This review was a follow up risk-based Learner and Educator review following a number of visits to Obstetrics and Gynaecology, the most recent being a Learner and Educator Review that took place in May 2021. The review panel spoke to one midwifery learner on the day. Health Education England conducted a survey following the review for the nursing and midwifery leaners of which six responded. The feedback varied but was broadly positive.

The review panel also noted the following areas requiring improvements:

The review panel acknowledged good examples of consultant engagement; however, it was advised that approximately 60 – 70% of consultants were not engaged in supporting trainees to achieve workplace-based assessments.

Trainees, clinical and educational supervisors advised that the local faculty group (LFG) meeting was not conducive for effectively reporting and managing concerns in its current format. The need for a robust process to be in place for monitoring and ensuring actions were met was acknowledged.

The review team heard that there was a culture of blame within the department. The current risk management processes were felt to be a barrier to learning, with trainees advising that there was not a safe space to discuss concerns or expected patient complications.

Due to ongoing concerns the review team requested for a follow-up Learner and Educator review to take place. The General Medical Council (GMC) were invited to attend the review as the department had been under enhanced monitoring since June 2021.

Subject of the review: Obstetrics and Gynaecology

Who we met with

11 Clinical and Educational Supervisors
Nine Obstetrics and Gynaecology Trainees working in the department
Associate Medical Director (Education, Research and Development)
Director of Medical Education
Medical Education Manager
Freedom to Speak Up Guardian
Guardian of Safe Working Hours
Clinical Director for Women and Children
Deputy Clinical Director for Women and Children
Obstetrics and Gynaecology College Tutor
Deputy Obstetrics and Gynaecology College Tutor
Interim Chief Medical Officer
Director of Operations Women and Children

Chief Nurse
Chief Executive Officer

Evidence utilised

The review panel received the following information and documents from the Trust in advance of the review:

Guardian of Safe Working Hours Report Quarter 1- April 2021- June 2021
Guardian of Safe Working Hours Report Quarter 2- July 2021- September 2021
Guardian of Safe Working Hours Annual Report- April 2020- March 2021
Maternity Services Briefing Paper to Public Trust Board November 2021
Summary of Consultant-led Teaching Sessions- October 2021-January 2022
Care Quality Commission Inspection Maternity Report October 2021
Draft Staff Survey Action Plan March 2021
Summary of Action Following a Never Event Incident
February 2022 Maternity Improvement Tracker and Bullying Data Deep Dive
NHS Staff Survey 2020 Management Report December 2020
Draft Women's People Strategy 2021-2023
Minutes from Women's and Children's Morbidity and Mortality Meeting- October 2021, December 2021 and January 2022
Summary of Serious Incidents and 72 Hour Reports- August 2021-January 2022
Information about Staff Friends and Family Data Collection for Maternity Improvement Tracker
Draft Divisional Governance Structure January 2022
Women & Children Division Organisational Development Plan- November 2021
Breakdown of the clinical and educational supervisors
Breakdown of learners in the department
Summary of Exception Reports from February 2021 and January 2022
Evidence of various teaching sessions, other educational opportunities and meetings
Summary of Risk Updates/Teaching Sessions
Local Faculty Group Minutes August 2021, October 2021, November 2021, December 2021 and January 2022
Health Education England Action Plan February 2022
Laparoscopy Course Feedback February 2022
Department Induction Programme February 2022
Department Induction Feedback October 2021
General Practice Trainee Induction Feedback February 2022
Minutes from Feedback Meeting with Trainees- 14 January 2022
Trainee rota December 2021 and January 2022

The review panel also considered information from the GMC National Training Survey 2019 and 2021 and Health Education England's (HEE) National Education and Training Survey (NETS) 2019 to 2021.

This information was used by the review panel to formulate the key lines of enquiry for the review. The content of the review report and its conclusions are based solely on feedback received from review attendees.

Review Panel

Role	Name, Job Title
Quality Review Lead	Dr Elizabeth Carty, Deputy Postgraduate Dean, Health Education England (London)
Specialty Expert	Dr Karen Joash, Head of the London Specialty School of Obstetrics and Gynaecology, Health Education England (London)
GMC Representatives	Jamie Field, Education Quality Assurance Programme Manager, General Medical Council Dr Angie Doshani, GMC Enhanced Monitoring Associate, General Medical Council
Lay Representative	Jane Gregory, Lay Representative, Health Education England
HEE Quality Representatives	Paul Smollen, Deputy Head, Quality, Patient Safety & Commissioning, Health Education England (London) Rebecca Bennett, Learning Environment Quality Coordinator, Health Education England (London)
Supporting roles	Ummama Sheikh, Quality, Patient Safety and Commissioning Officer, Health Education England (London)

Executive Summary

The review panel thanked the Trust for accommodating the review. The review panel was particularly impressed and appreciative for the extensive pre-review evidence and preparation that the Trust had done prior to the review. The Trust representatives thanked their colleagues in the department for the hard work so far. The Trust representatives acknowledged that there was still a lot of work to do and changes to be implement but noted that significant progress had been made.

The review panel acknowledged several areas of good practice, including induction, supportive environment, and inclusion of trainees in the chairing of Local Faculty Group (LFG) meetings. The review panel was also pleased to hear that there had been a profound change in the culture in the department and commended the involvement and support from the senior leadership and Trust Board.

It was reported there had been longstanding trainee rota gaps which had made access to teaching, including simulation, and other educational opportunities, such as scanning acute gynaecology patients, difficult. The review panel noted that the Trust was aware of this and was working on recruitment to these gaps.

The review panel was concerned that trainees would not be comfortable with their friends or family being treated for acute gynaecological issues. The review panel noted several concerns with the acute gynaecology referral pathway and communication with the emergency medicine department. The review panel was also concerned about the availability of supervision and continuity of care for the ante-natal and post-natal wards. The review panel was particularly concerned to hear that the labour ward scanner was not working properly and that trainees felt this was a patient safety issue. It was acknowledged that the Trust was aware of these issues and was taking steps to make changes, however it was felt that more work was needed to resolve these issues promptly.

This report includes a number of requirements and recommendations for the Trust to take forward, which will be reviewed by Health Education England (HEE) as part of the three-monthly action planning timeline. Initial responses to the requirements below will be due on 1 September 2022.

Review Findings

This is the main body of the report and should relate to the quality domains and standards in HEE's Quality Framework, which are set out towards the end of this template. Specifically, mandatory requirements in the sections below should be explicitly linked to the quality standards. It is likely that not all HEE's domains and standards will be relevant to the review findings.

Requirements

Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
OG1.5a	Trainees reported significant issues with communication with the Emergency Medicine (EM) department, particularly in relation to the non-specific abdominal pain pathway. Trainees noted that there had been instances of inappropriate behaviour when discussing referrals and reported that the issues were particularly prevalent at night when the senior trainee workload was higher. The Trust representatives confirmed that they were aware of these issues and were currently working on improving the relationship with EM and the referral pathway. The review panel recommended that trainees were included in this improvement work.	Please provide evidence of the work being done to improve the non-specific abdominal pain pathway and the communications and relationships with colleagues involved in referrals from the emergency department to the on-call gynaecology team. Please also provide feedback from trainees on this topic, LFG meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
OG1.5b	It was reported that the labour ward scanner was old and took a long time to turn on, it was noted this was a particular issue in emergencies. It was also reported that there was no central Cardiotocography (CTG) monitoring system in place, although trainees reported that there had been action to implement this but noted that progress had been slow.	The Trust must ensure trainees have access to essential equipment to carry out their role safely. Please provide evidence that the labour ward scanner has been replaced. Please provide evidence of how the safety of the training environment is monitored if a central monitoring system is not being used. Please also provide feedback from trainees on this topic, LFG meeting minutes or other evidence.

		Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
OG3.5	The review panel was concerned about the continuity of care and access to clinical supervision on the ante-natal and post-natal wards. It was reported that the elective caesarean section consultant was responsible for covering these wards however trainees reported that the ward round was usually trainee led and the consultant did not attend.	The Trust must ensure that trainees have access to appropriate levels of clinical supervision and learning opportunities when working on the ante-natal and post-natal wards. Please provide evidence that clinical supervision on the ante and post-natal wards meets trainees needs. Please provide feedback from trainees on this topic, LFG meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
OG5.6	It was reported that there had been longstanding trainee rota gaps which had made access to teaching, including simulation, and other educational opportunities, such as scanning acute gynaecology patients, difficult.	The Trust must ensure that trainees are able to be released for teaching and training opportunities. Please provide feedback that the rota allows trainees to be able to attend teaching and training opportunities. Please provide feedback from trainees on this topic, LFG meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.

Immediate Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
	N/A	
Requirement Reference Number	**Progress on Immediate Actions**	**Required Action, Timeline and Evidence**
	N/A	

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.

Reference Number	Related HEE Quality Framework Domain(s) and Standard(s)	Recommendation
O&G1.5c	1.5	The review panel recommends that the Trust considers the use of central Cardiotocography (CTG) monitoring as this would improve the safety of the training environment by allowing remote surveillance

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/Professional Group/Department/Team	Good Practice	Related HEE Quality Framework Domain(s) and Standard(s)
The Trust Board	The Trust representatives reported that a Non-Executive Director had been leading the response to the HEE action plan. The review panel was pleased with this good practice and commended the Trust Board awareness and involvement in the changes within the department.	2.4
Postgraduate Medical Education Team & Trainee representatives	The review panel was particularly impressed that a senior trainee representative had been co-chairing these meetings and noted that this was an excellent example of good practice.	2.6

HEE Quality Domains and Standards for Quality Reviews

HEE Standard	HEE Quality Domain 1 Learning Environment and Culture	Requirement Reference Number
1.1	**The learning environment is one in which education and training is valued and championed.** The Trust representatives acknowledged the importance of improving the learning environment for all staff in the department, not only the trainees. The Trust representatives noted that hosting trainees for their training was a privilege and acknowledged that trainees also provided a benefit to the learning of the other members of staff in the department. The Trust representatives advised the review panel that trainees appeared happier than before and noted that supervisors had been more supportive. The Trust representatives were very complimentary of the department and commended the engagement of the department in education and improvement work. The supervisors reported that there had been changes in the team which had helped bring new ideas and fresh perspectives to the department. The Trust representatives informed the review panel that the department was developing a people strategy which included plans to enable development and career opportunities for all staff in the department. It was noted that this was aligned with the wellbeing strategy too. The trainees reported that they had noticed an improvement in the obstetrics learning environment but felt that further improvements were needed for gynaecology. The supervisors reported that there had been a significant change in the department and noted that they had enjoyed their roles as educators. It was reported that the supervisors had received a lot of support from the division and noted that there had been a great deal of work done to make the changes required following interventions by HEE, the GMC and other regulators. Supervisors were particularly complimentary of the efforts from the former Director of Medical Education (DME), College Tutor (CT) and Deputy College Tutor (DCT) to drive change.	
1.3	**The organisational culture is one in which all staff are treated fairly, with equity, consistency, dignity and respect.** Some trainees reported that there was an issue with the culture of the Gynaecology Direct Referral (GDR) team. It was noted that experiences had varied, with some days better than others. Some trainees reported that they had experienced inappropriate	

	behaviour from members of staff and noted that behaviours varied depending on the mood of the individuals in the team. Trainees reported that there had been instances of unprofessional behaviour where difficult conversations or inappropriate feedback was given within hearing distance of the patients.	
1.5	**Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.** Trainees reported significant issues with communication with the Emergency Medicine (EM) department, particularly in relation to the non-specific abdominal pain pathway. It was reported that there had also been issues with inappropriate referrals which trainees had found challenging as it added to their workload unnecessarily. It was reported that there had been referrals made without a valid gynaecology issue and it was noted that trainees were concerned about the quality of care for these patients. It was also reported that incomplete assessments and sub-optimal patient management prior to referral to gynaecology had caused instances where patients had to be referred back to the EM team, which caused tension between the departments and frustration for patients. Trainees also noted that the maternity unit was a considerable distance from the EM department which exacerbated issues caused by inappropriate referrals and bleeps. Trainees also noted that they were often bleeped without an appropriate disclosure of the patient condition and other important clinical information which delayed urgent treatment when the trainees arrived in the EM department. The supervisors informed the review panel that they were aware there were issues with patients not being referred appropriately. Trainees also reported that there had been instances of inappropriate behaviour when discussing referrals with EM colleagues and reported that the issues were particularly prevalent at night when the senior trainee workload was higher. The supervisors confirmed that they were aware of the issues with inappropriate behaviour and difficult conversations between EM colleagues and the trainees. The Trust representatives confirmed that they were aware of these issues and were currently working on improving the relationships with the EM department including the referral pathway. The supervisors reported that they had started a dialogue with to help discuss the issues. The review panel was informed by Trust representatives that the new referral pathway aimed to clarify the team responsible for the non-specific	Yes, please see OG1.5a Yes, please see OG1.5a

	abdominal pain patients. The supervisors reported that they believed the new referral pathway would help alleviate some of the issues, particularly out of hours. The Trust representatives reported that there was good engagement in the improvement work and both consultants and trainees were involved in this process. The trainees reported that an EM consultant had joined one of the Local Faculty Group meetings (LFGs) to discuss the issues with trainees, however the trainees noted that this had not been a particularly productive session and trainees felt their concerns had been dismissed. Trainees also reported that they felt the behaviour in this meeting was not appropriate and reported that it had been suggested that the trainees had been bullying the staff in the EM department. The review panel recommended that more work was done to ensure trainees felt included in this improvement work. The Trust representatives informed the review panel that the EM department were under a lot of pressure and there had been a tendency to expect a quick response from trainees. The Trust representatives acknowledged that the manner of communication in a highly pressurised environment was important. Trainees reported that they felt there was a lack of understanding within the EM team about the higher trainee on-call workload and the additional workload that was created by inappropriate referrals and pressure from the EM team. The Trust representatives informed the review panel that there were plans to educate the EM team about the trainee role and responsibilities when on-call to enable a better understanding of the trainee workload. It was also reported that the issue had been raised at the Internal Professional Standards meeting with all the specialty leads from across the Trust. It was reported that the labour ward scanner was old and took a long time to turn on, it was noted this was a particular issue in emergencies. The trainees informed the review panel that they felt this was a patient safety issue. Trust representatives acknowledged that this was an issue and reported that a new scanner had been ordered, however trainees were not aware of this. It was reported that there was a new handheld scanner that could be connected to smartphones, however it was noted that there were limitations and there had been issues with connecting it to some phones. It was also reported that there was no central Cardiotocography (CTG) monitoring system in place, although trainees reported that there had been action to implement this, but progress had been	Yes, please see OG1.5a Yes, please see OG1.5b Yes, please see OG1.5b and OG1.5c

	slow. The trainees noted that regular updates on the progress of this work would have been appreciated. The review panel was informed that the handover for labour ward took place in the morning, afternoon, and evening. Trainees advised that the handovers were effective, free of distractions and followed a clear structure, with time protected in the rota for them. It was also noted that the handover did not start until all relevant members of the team were present. Trainees also informed the review panel that there was always a consultant present for the ward round and other members of the Multi-disciplinary Team Meeting (MDT)also attended, for example anaesthetics and midwifery representatives. The trainees confirmed there were no concerns with the labour ward environment. The Trainees reported that when there was a doctor covering triage it felt much safer and manageable. It was noted that there were concerns when it was busy as the triage and day assessment unit was not covered. However, trainees noted they had always been able to escalate to the consultants when this was an issue. Trainees also reported concerns about the gynaecology outlier patients, it was noted that there was a risk of these patients being missed. Trainees noted that sometimes the patients would be written on the labour ward whiteboard. Trainees informed the review panel that they believed these patients should been added to the gynaecology patient list, but this did not happen all the time. Trainees reported that they would be happy for their friends and family to be treated by the obstetrics team on labour ward and the elective gynaecology list. However, generally trainees reported that they would not feel comfortable for their friends and family to be treated for acute gynaecological issues. It was also noted that trainees would not recommend treatment in the EM department.	
1.7	**All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.** The Trust representatives reported that there was a close relationship between education leads, the trainees and supervisors. It was noted this relationship had been fostered to ensure trainees and supervisors felt able to give feedback. Trainees confirmed that consultants and education leads were approachable, and all trainees reported they felt comfortable raising concerns. Trainees reported that the concerns they had raised had been acted on quickly and generally trainees had received feedback on the outcome.	

	The review panel was pleased to hear that there had been a profound change in the culture in the department. Trainees reported that overall, the environment was supportive, and they had not experienced any particular issues with the culture of the department. The review panel was informed by trainees that there was good team working and all staff had been approachable. Trainees reported that they felt comfortable raising concerns and that the department was very supportive. Trainees also reported that serious incidents had generally been handled well with sufficient support and feedback provided. The Trust representatives reported that they met with the trainees in March 2022 and trainees reported that the support in the department was good and the culture was kind and supportive. Trust representatives reported that when asked about experiences of bullying and undermining in the department, trainees reported that they could not recall any instances of bullying and undermining. The Trust representatives also reported that trainees had noted the pastoral support system was working well too. The Trust representatives reported that they had organised a workshop to address blame culture in the department. It was also reported that the Trust had organised training sessions on debriefing and providing feedback for serious incidents. The review panel heard that the Trust representatives believed new leadership appointments within the department had contributed significantly to the improvement in the culture. The Trust representatives also informed the review panel that the most recent Care Quality Commission (CQC) review in October 2021 had also found an improvement in the culture in the department. The Trust representatives informed the review panel that trainees had reported that they felt supported to exception report when necessary. Trainees confirmed that they had been encouraged to exception report when they needed to. Some trainees noted that they have not needed to exception report as there was always someone to handover to.	
1.9	**There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence-led practice activities and research and innovation.** The Trust representatives informed the review panel that there were plenty of opportunities for audits and quality improvement projects (QIPs) and there was a desire to get trainees involved in	

	this work. However, the Trust acknowledged that the rotas needed to be adjusted to enable trainees to do this. The Trust representatives advised that trainees had been offered time off in lieu if they had conducted audits or QIPs in their own time.	
1.10	**There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.** Most trainees reported that they had been well supported throughout the serious incident (SI) process however some reported that this was not their experience and there was not any support made available for them. Some trainees also reported that they did not know who to contact if they wanted to request support following an SI. Trainees who had reported a positive experience advised that senior consultants had conducted debriefs following the incidents and there had been follow up support once the report had been published. The Trust representatives reported that trainees had feedback that the risk management update emails had been helpful in providing feedback and learning from incidents.	
1.12	**The learning environment promotes multi-professional learning opportunities.** The trainees reported that the obstetrics experience had been positive and advised they had received good support from the midwifery team. Some trainees informed the review panel that the relationship between midwives and doctors had been the best they had experienced in their training. It was noted that differences in opinions were discussed respectfully. Trainees reported that there had been some issues with rota gaps within the midwifery team which had added to the pressure on the team. Trainees also reported that the theatre teams had been great, and their elective experience had been exemplary.	

HEE Standard	HEE Quality Domain 2 Educational Governance and Commitment to Quality	Requirement Reference Number
2.1	**There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.** The Trust representatives advised that the senior management team had been running coffee mornings to engage with the workforce in the department.	
2.4	**Education and training issues are fed into, considered and represented at the most senior level of decision making.** The Trust representatives reported that a Non-Executive Director (NED) had been leading the response to the Health Education England (HEE) action plan. The review panel was pleased with this good practice and commended the Trust Board awareness and involvement in the changes within the department. It was reported that the HEE action plan was mentioned at the Quality and Safety Sub-Board Committee often and it was noted that this sub-committee communicated with the Trust Board. The Trust representatives and supervisors reported that the support from the Trust Executive Team and Trust Board had been excellent.	
2.6	**Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.** The review panel was pleased that regular LFGs had been taking place and were working well. The review panel was particularly impressed that a senior trainee representative had been co-chairing these meetings and noted that this was an excellent example of good practice. The Trust representatives recognised that the attendance at these meetings had not been great but noted it had improved. The trainees confirmed that the LFGs were working well and that the action logs were getting completed in a more timely manner. The trainees informed the review panel that they felt able to provide feedback to the trainee representative and could do so in an anonymous manner if they preferred. The trainee representative reported that there had not been as much anonymous feedback recently as trainees felt more able to provide open feedback. The Trust representatives discussed methods for monitoring progress and measuring success. It was reported that there was	

	a monthly maternity improvement group which was chaired by the Chief Executive Officer (CEO). The review panel was also informed that this group included patient representatives and a NED. It was noted that the group monitored the HEE action plan and scrutinised different metrics, including clinical indicators of care and metrics for training. The Trust representatives confirmed that progress was also monitored via the LFG utilising trainee feedback. The review panel was also informed that the Trust continued to monitor issues on their action register until the action had been embedded. The supervisors reported that the former DME had regularly attended the consultant meetings to offer support and maintain a focus on education which they had found helpful.	
2.7	**There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.** The Trust representatives reported that there were plans to discuss the Ockenden review of maternity services with the maternal network. The supervisors confirmed that working with other hospitals in the network had really helped with the changes in the department.	

HEE Standard	HEE Quality Domain 3 Developing and Supporting Learners	Requirement Reference Number
3.1	**Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.** The Trust representatives advised that there was an open-door policy for trainees to approach education leads if needed, and that trainees were offered pastoral support for issues outside of work. The review panel was also informed that Human Resources (HR) hosted weekly staff engagement sessions. The Trust representatives noted that this had had a positive impact on the staff survey results. It was also noted that trainees had access to the employee assistance programme and were informed about this at their induction. The Trust representatives informed the review panel that there was a variety of wellbeing support for trainees and trainers had access to. The Trust representatives reported that the midwives in the department ran mindfulness session three times a week and trainees were encouraged to attend. Some trainees confirmed that these mindfulness sessions were helpful. The Trust representatives noted that the department had arranged team	

	social events and hosted regular coffee mornings. In addition to this Trust representatives reported that the Trust offered other wellbeing activities such as access to counselling, yoga, choir and Zumba. The review panel was pleased to hear that trainees and supervisors had access to a wide range of wellbeing support within the department and the Trust. The review panel noted that the mindfulness sessions on the labour ward were particularly impressive and noted that there had been an effort to arrange team education and social events.	
3.5	**Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.** The review panel was concerned about the continuity of care and access to clinical supervision on the ante-natal and post-natal wards. It was reported that the elective caesarean section consultant was responsible for covering these wards. However, trainees reported that the ward round was usually trainee led and the consultant did not attend. Trainees reported that there was a different higher trainee leading the ward round each day which affected continuity and was frustrating for patients. It was noted that that the trainee leading the ward round discussed the patients with the consultant after the ward round and trainees confirmed that they were able to contact the consultant if necessary. The trainees reported that the ante-natal patients were also discussed at the labour ward morning handover and that consultants were able to cross cover if required. The supervisors confirmed that they were aware of the issues but informed the review panel that more consultants were needed to cover this. It was noted that there were sessions planned to discuss how to address this with the consultants they have already, but it was noted that this was difficult. The Trust representatives also acknowledged that there was an issue with nominated ward consultant cover. The supervisors informed the review panel that the necessary evidence had been gathered to support the business case to expand the consultant workforce. It was noted that the business case was almost complete and would be presented soon. However, the supervisors clarified that there was enough cover to deliver safe care and ensure that trainees were adequately supervised. The Trust representatives advised that clinics were cancelled if consultants were on annual leave and appropriate cover was sought in the event of sick leave or unplanned leave. Trainees reported that the obstetric unit was very supportive and that the on-call experience had been good. It was noted that trainees had not felt out of their depth and consultants were available if they needed support. Trainees informed the review panel that the supervision arrangements on the unit allowed the	Yes, please see OG3.5

	trainees to work within their competence. Trainees also reported that the workload on labour ward was manageable. Trainees reported that out of hours the senior trainees were very supportive and provided support in the EM department when necessary. Trainees also reported that the department was very supportive and understanding of the high workload at night.	
3.6	**Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.** The Trust representatives reported that they had reduced the number of educational supervisors to a core group and attempted to allocate trainees based on the supervisors' special interests/specialties.	
3.7	**Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.** The Trust representatives reported that there had been work done to change the culture of assessments and encourage consultants to offer assessments regularly and engage more to ensure they were completed in good time. It was reported that the Trust had been auditing this. Trainees reported that there had not been any issues with completing assessments or their logbooks.	
3.9	**Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.** The trainees reported that there had been a three-day induction when they started and that all staff had been friendly and welcoming. Trainees were particularly impressed that senior managers attended the first few handovers to introduce themselves to trainees. It was reported that the first half day was a Trust induction, and the remainder of the time was dedicated to the departmental induction. Trainees reported that the induction was mostly face-to-face, but that some people joined remotely. The review panel was informed that the departmental induction consisted of a mixture of presentations, skills and surgical simulation sessions. Trainees did not report any concerns with their induction.	

HEE Standard	HEE Quality Domain 4 Developing and Supporting Supervisors	Requirement Reference Number
4.1	**Supervisors can easily access resources to support their physical and mental health and wellbeing.** The supervisors reported that they had access to a number of different resources to support their wellbeing. It was noted that the Trust was offering a lot of support for health and wellbeing. Supervisors also reported that they had developed their own methods for supporting their wellbeing and this was being shared within the consultant group. The supervisors informed the review panel that a large contributor to their wellbeing was being able to provide the best care for their patients and therefore efforts to improve the working environment, processes and equipment were most helpful. It was also reported that supervisors did not feel the workforce was large enough to cover all the required areas and that more staff were necessary.	Yes, please see OG5.6
4.2	**Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.** The supervisors confirmed they had sufficient time allocated in their job plans for education responsibilities.	
4.7	**Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.** The supervisors reported that the Postgraduate Medical Education Department (PGME) had offered training sessions on giving effective feedback across a number of different departments including O&G. Supervisors reported that they felt well supported by PGME. The supervisors also informed the review panel that there was eLearning available for development and supervisors underwent an educational appraisal every three years.	

HEE Standard	HEE Quality Domain 5 Delivering Programmes and Curricula	Requirement Reference Number
5.1	**Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.** Trainees reported that the gynaecology elective surgery opportunities and experiences had been exemplary. The	

	supervisors reported that the Trust offered a unique patient group and challenges which contributed to a varied learning environment. Trainees also reported that the exposure to challenging obstetrics cases was helpful, and that the patient mix at the Trust was interesting and offered opportunities to develop. Trainees reported that whilst the gynaecology surgery experience was good, the acute gynaecology experience needed improvement. It was reported that there was limited exposure to gynaecology scanning as there were not as many professionals as trainees had expected who were able to scan. Trainees advised they believed this was a missed learning opportunity and noted it was particularly difficult to get experience in this area. The supervisors reported that previously trainees had been very good and ensuring they scheduled time on their rota for scanning, it was noted that this was happening with some trainees. The supervisors confirmed that not all consultants had scanning skills, it was noted that it was not always possible to allocate a consultant with scanning skills to the on-call. The supervisors reported that there was a regular scanning session on alternate Mondays and the department was exploring giving other consultants allocated time in their job plans for this too. Supervisors noted that the majority of the service provision ran parallel to scanning commitments, therefore if there were more consultants there could be more dedicated scanning sessions. Some trainees also reported that they did not think that the higher trainees gained much from seeing gynaecology patients in the EM department and clarified that they believed this was more useful to a more junior trainee. The supervisors reported that there was an MDT every other Tuesday to discuss complex cases and the sonography team was also invited to attend. Trainees also reported that there was a weekly CTG meeting which was well attended by both trainees and consultants. It was noted that there was a rota of presenters for this meeting. Trainees also informed the review panel that there was a foetal medicine specialist who offered ad-hoc CTG teaching and support. The Trust representatives informed the review panel that trainees had fed back that the teaching was good and offered good curriculum coverage. It was also noted that teaching was recorded for trainees to catch up if necessary. The Trust representatives informed the review panel that trainees had been offered laparoscopy training and the feedback from trainees had been positive. The Trust representatives also discussed ultra-sound training and noted that the trainees had given excellent feedback about the training the Trust had provided.	

	Trainees reported that the offsite simulation training had been good but noted that there was not much on-site simulation training. The trainees reported that there was ad-hoc ward-based simulation training but noted that this time was not protected so was difficult to attend. The trainees reported that they had been encouraged to do the Practical Obstetric Multi-Professional Training (PROMPT) when they first started. The Trust representatives reported that they were aiming to improve teaching and opportunities in leadership, risk management, governance, and quality.	
5.6	**Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.** The Trust representatives informed the review panel that they believed there had been improvement in the rota management and the balance between service provision and education had improved. The Trust representatives also reported that the rota was managed in a way which enabled the educational opportunities to be shared equally amongst the trainees. The Trust representatives reported that the trainees had access to protected teaching time every Friday afternoon. Trust representatives confirmed that there had not been any issues with releasing trainees for the Friday afternoon teaching. The review panel heard that the Trust utilised the workforce to cover and allow trainees to attend. Trainees reported that they were allocated time on their rota to attend teaching but noted that not all trainees were scheduled to attend teaching at the same time. It was noted that the trainee responsible for the rota ensured that all General Practice (GP) trainees were released for their programme teaching on Thursdays. It was reported that there had been longstanding trainee rota gaps which had made access to teaching, including simulation, and other educational opportunities, such as scanning acute gynaecology patients, difficult. Trainees reported that they felt they were constantly having to fill on-call rota gaps. Trainees also informed the review panel that a reduction in the workload for acute gynaecology and early pregnancy would help trainees with accessing training opportunities. The Trust representatives informed the review panel that they had recently recruited locally employed doctors to cover the rota gaps at a junior level and were working on the recruitment to the higher trainee gaps. Trainees reported that the gynaecology ultra-sound training was better for more junior trainees rather than specialty trainees, but it was noted that the junior trainees often could not attend due to the rota gaps. Trainees reported that obstetrics scanning training	Yes, please see OG5.6

	was available and there was a dedicated session every Friday which was good. The Trust representatives acknowledged that the rota gaps had also prevented trainee involvement and exposure to clinical governance work. It was reported that there was a new Head of Governance, and they were doing a lot of work to make improvements to governance within the department. However, it was acknowledged that trainee involvement in clinical governance could be improved further. Trainees reported that they were not aware of many of the national quality workstreams that the review panel mentioned, some trainees reported awareness of the Saving Babies' Lives initiative.	

HEE Standard	HEE Quality Domain 6 Developing a sustainable workforce	Requirement Reference Number
6.1	**Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.** The Trust representatives reported that when they met with the trainees in March 2022, all trainees reported that they would recommend the department as a place to train and noted it was a good place to work. All trainees confirmed that they would recommend the training environment to colleagues. Some trainees noted they had some reservations due to variability of consultant decision making but noted overall it had been a positive experience. The trainees reported that prior to starting at the Trust they had been aware of the poor reputation the department had. However, trainees noted that the department had been very kind and welcoming, and their experience had been very different to what they had expected. The supervisors informed the review panel that they wanted to work with the wider sector to improve the reputation of the department and improve that perspective. Trainees noted that they had seen that the department was making and effort to improve things.	

Report Approval

Quality Review Report completed by	
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Date signed	12 May 2022

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Final Report submitted to organisation	19 May 2022