Education Quality Interventions Review Report

East Kent Hospitals University NHS Foundation Trust
Trauma and Orthopaedic Surgery
Risk-based Review

South East
Date of Review: 28 July 2023
Date of Final Report: 16 October 2023

Review Overview

Background to the review

This risk-based quality review was focused on core and higher specialty training in Trauma and Orthopaedic Surgery at William Harvey Hospital, East Kent Hospitals NHS Foundation Trust.

The review was arranged to explore the quality of the clinical learning environment following concerns raised via the General Medical Council National Training Survey (GMC NTS) 2022 results which were triangulated with intelligence received via the Kent, Surrey and Sussex (KSS) School of Surgery. The 2022 GMC NTS results showed several below outliers which were highlighted for further quality monitoring by the former Health Education England; responses provided by the Trust during this process did not provide adequate assurance that the issues had been satisfactorily addressed.

The aim of the review was to understand whether the clinical learning environment met the Quality Standards and to identify quality improvement actions where necessary.

Who we met with

The panel met with five core (CT) and higher specialty (HST) doctors in training in Trauma and Orthopaedic Surgery at William Harvey Hospital (WHH). Their training grades ranged from CT2 to ST8.

The panel met with four clinical and/or educational supervisors in Trauma and Orthopaedic Surgery.

The panel met with the following Trust representatives:

- Chief Medical Officer
- Executive Director of Strategic Development and Partnerships
- Medical Director for Trauma and Orthopaedic Surgery (Trust-wide)
- Clinical Lead for Trauma and Orthopaedic Surgery (William Harvey Hospital)
- Clinical Associate Director of Medical Education
- Associate Director of Medical Education
- Medical Education Quality and Governance Manager
- Quality Assurance Lead for Postgraduate and Undergraduate Medical Education
- Guardian of Safe Working

Evidence utilised

The following evidence was utilised to inform the key lines of enquiry for this review:

- GMC National Training Survey 2022 and 2023 results
- National Education and Training Survey 2022 results
- Education Provider Self-Assessment 2022
- EKHUFT Surgery Local Faculty Group minutes

Review Panel

- Professor Jo Szram, Postgraduate Dean (Education Quality Review Lead)

- Miss Alison Crocker, Associate Dean
- Miss Ginny Bowbrick, Head of School of Surgery
- Jacqueline Ewers, Lay Representative
- Max Eager, Quality Support Manager
- Sarah Stanbridge, Quality Project Officer (scribe)

Executive Summary

The panel thanked the Trust for accommodating this quality review which was arranged in response to concerns highlighted via the 2022 GMC NTS and intelligence received via the School of Surgery. The panel recognised the work already undertaken by the Medical Education Team and colleagues from the Trauma and Orthopaedic (T&O) department in response to the concerns, including a survey and focus groups, to understand the experiences of doctors in training and supervisors in the department. The panel noted that key themes heard from doctors in training and supervisors during this review aligned with those identified by the Medical Education team during internal focus groups.

Areas which were particularly noted to be working well:

- Doctors in training valued the training opportunities available at the Elective Orthopaedic Centre in Canterbury, noting this provided good training access to arthroplasty cases.
- Doctors in training generally felt supported by consultants in the department.
- The work of the Trauma Coordinators was highly valued by doctors in training.
- The structure of the consultant-led daytime on-call rota was reported to work well in terms of allowing new admissions to be seen in a timely manner and offering scope to increase educational opportunities in the department.
- The department was noted to have provided good core training experience in T&O this year.
- Evidence that doctors in training felt able to raise concerns within the organisation.

Areas identified for improvement:

The panel considered that immediate action was required to address concerns relating to inappropriate practices in relation to locum ‘SHO’ doctors consenting patients at night and insufficient exposure to trauma training opportunities to meet ST3 curriculum requirements. The Trust have provided assurance in response to the two Immediate Mandatory Requirements issued and further monitoring requirements have been agreed.

Mandatory requirements were issued aligned with NHSE Quality Standards in relation to the following findings:

- Concerns around the reliance on Resident Medical Officers (RMOs) to provide out of hours cover and the associated impact on the working hours and training experience of the on-call HSTs who were frequently called overnight to provide support.
- The panel heard that doctors in training were sometimes required to travel between sites during sessions, which the panel considered to be an inappropriate use of training time.
- Significant concerns were heard regarding the culture in T&O theatre at WHH and the impact of this on theatre efficiency and training experience.
- The panel heard reports of perceived animosity and rivalry between T&O consultants at the WHH and QEQM sites.
- It was reported that adverse events were not discussed openly at the Morbidity and Mortality meeting.
- The panel heard there was no nominated Trauma and Orthopaedic Surgery doctor in training representative for the Local Faculty Group.
- The panel heard that changes in process to address concerns regarding supervision of clinics had not yet been universally accepted within the department.

- The panel heard examples where supervisors had not been allocated time in their job plans for educational supervision in line with the agreed tariff.
- The panel heard that organised departmental teaching had been lacking since the opening of the Elective Orthopaedic Centre.

The panel also identified an action for the School of Surgery to address regarding the timing of a course impacting on attendance at induction.

Requirements will be monitored via an action plan and a work programme meeting will be considered to review progress.

Review findings

The Clinical Associate Director of Medical Education presented an overview of the Trust's work to address the concerns which had led to this review; details have been included under the relevant domains of this report. It was acknowledged that the 2022 GMC NTS results had raised concerns, and although the 2023 results had shown some improvement, these had suggested that there remained work to be done with respect to teamwork and educational supervision.

The panel heard that the Medical Education team, working collaboratively with the T&O department, had carried out an internal survey and focus groups with doctors in training and supervisors in T&O to triangulate data and understand what was happening in the learning environment; key findings were presented to the panel. The Medical Education team presented their recommendations in response to their findings and welcomed further information based on the findings of this review to guide further action.

The Trust perceived that the opening of the Elective Orthopaedic Centre (EOC) in Canterbury in July 2021 had had a positive impact on the T&O department overall and noted that applications had been submitted for the EOC to be a national Centre of Excellence as an elective hub and revision centre from 1 September 2023. Regarding the impact of the EOC on training, both positives and negative impacts were noted as detailed within the relevant domains of this report.

Quality Domain 1: Learning Environment and Culture

Impact of staffing and workload on patient and training experiences

Doctors in training expressed concern regarding the reliance on Resident Medical Officers (RMOs) provided by an agency to cover out of hours work. It was reported that the RMOs often started work in the Trust with no previous experience of working in the NHS or in the UK and were put on 13-hour night shifts, seven nights in a row, often without log-in details for the computer systems, with an expectation that they would be responsible for seeing patients and making management plans. The panel heard that some of the RMOs initially provided by the agency who had gained experience in the Trust were now working day shifts and did not work at night. It was confirmed that there was an outreach team but no Hospital at Night system in the Trust.

When doctors in training were asked about patient safety and harm in relation to these concerns, they indicated that patients were safe overnight with input from the on-call HST. The panel heard that the on-call HST would encourage the RMOs to contact them with any concerns. However, the panel were informed that some RMOs were consenting patients overnight and concerns were expressed regarding the completion of the consent forms; an example was described in relation to the information recorded regarding the operative risks for a specific patient. **See Immediate Mandatory Requirement reference IMR-TO1.**

The panel were informed that higher specialty doctors in training were non-resident during their on-call shifts. The Trust perceived that HST doctors were called occasionally for advice after midnight, which was reported to be within their contractual obligations. However, doctors in training indicated that they were regularly called during the night; the panel heard that during most on-call shifts the on-call HST would remain in the hospital until 01:00 before going to the on-call room, then would usually be called back twice before returning to work in the department at 06:00. When asked, doctors in training reported they did not submit exception reports in

relation to this and some indicated they did not know how to submit exception reports. **This will be linked to existing mandatory requirement reference MR-TW8 issued at previous quality intervention.** In response to a question around potential alternatives to the current out of hours arrangements, HST doctors indicated they would not been keen to change to a system where they worked a week of night on-call shifts as this was perceived to have a greater impact on missed training opportunities during the daytime compared to the current 24 hour on-call shift arrangement. It was confirmed that core surgical doctors in training did not participate in the on-call rota in T&O.

The panel heard that doctors in training had raised their concerns regarding the reliance on RMOs on multiple occasions within the department and had been informed there was no solution. Doctors in training perceived that the employment of Trust grade doctors to support the out of hours rota would address the issue and the panel were informed that a business case had been presented to the Trust. The panel heard a view from the supervisor group that it had been difficult to recruit to this tier in the past. **See mandatory requirement reference MR-TO3.**

Supervisors suggested that the opening of the EOC had impacted on the continuity of care for inpatients at WHH, which led some to express concern about their patients. The panel heard that consultants had been given more commitments and were less frequently on-site at WHH, so were more reliant on doctors in training and RMOs to look after inpatients. Supervisors also perceived a potential impact on training, as consultants were less often on site to review inpatients with the HSTs. The panel heard from the supervisor group that although the training programme was designed such that doctors in training spent the day at one site, some doctors in training were travelling between sites during sessions, for example they would see inpatients at WHH before travelling to the EOC. However, this concern had not been expressed by doctors in training during the review; on the contrary a comment was noted indicating that some doctors in training stayed at the EOC for the whole day when rostered to work there. **See mandatory requirement reference MR-TO4.**

Theatre culture

The Trust were aware of concerns regarding the culture in T&O theatres at WHH and referenced the findings of their internal focus groups. It was recognised that cultural issues could be difficult to raise within an organisation and the panel were encouraged that doctors in training had evidently felt able to express their concerns to the departmental and medical education teams, thus commended those involved in fostering an environment in which doctors in training felt safe to do so.

During the review, both doctors in training and supervisors described concerns regarding the culture in the T&O theatre at WHH. Doctors in training described animosity from the Trauma Theatre team towards surgeons, including doctors in training, Trust grade doctors and some consultants. Alleged behaviours were reported to include resistance to requests from surgeons, for example in relation to the surgical instruments used, and impatience with doctors in training who were operating. The theatre culture at WHH was reported to contrast with that of the Queen Elizabeth the Queen Mother hospital (QEQM) and the EOC, which were described positively.

Doctors in training observed that consultants' reactions to these behaviours varied depending on the individual consultant. Some doctors in training indicated they themselves had learned how to manage the situations to avoid conflict, nevertheless there was a general consensus that

the culture remained a significant issue and a reflection that collaboration between teams was required for maximal efficiency.

The supervisors present perceived that poor behaviours tended to be more often directed towards doctors in the earlier years of higher specialty training. It was suggested that often the Trauma Theatre team responded more positively to consultants and that untoward behaviours were less frequent when consultants were present. Supervisors perceived that doctors in training may be made to feel uncomfortable, under pressure and not enjoy operating, which could make them reluctant to put themselves forward to operate. The panel heard that Trauma Theatre staff would cite concerns around patient safety if challenged on their behaviours.

The panel heard from both doctors in training and supervisors that behaviours demonstrated by senior team members of the Trauma Theatre team were being passed on to and learned by junior and student team members. It was reported that senior members of the Trauma Theatre team had been overheard on more than one occasion speaking with junior members in a manner perceived as ‘bragging’ about their behaviour towards surgeons. The panel heard that behaviours extended to alleged bullying of some individuals and one suggestion of racism was noted; these were second-hand accounts and further details were not provided to the panel.

The panel were also informed that the Trauma Theatre team would regularly resist the number of cases scheduled on a given list, deeming this to be unrealistic based on the total number (usually four or five) without considering the case-mix. This was reported to result in cancelled operations because the Trauma Theatre team feared the list would overrun, however in practice such lists would often finish at 16:00 and it was suggested that the Trauma Theatre team would deliberately slow down during the afternoon. This was perceived to unnecessarily limit the number of operations completed on a given day and doctors in training referred to experiences in other departments where comparable lists had been completed. Concern was expressed about the potential impact of cancelled operations on patient experience.

The panel heard further comments relating to theatre efficiency. Doctors in training commented that operating lists sometimes appeared to start relatively late in the morning and that the Trauma Theatre team took a 45-minute lunch break together each day, during which time no operating could take place. Doctors in training confirmed there were no issues with patients being admitted to recovery, but there could be delays in bringing patients to theatre from the ward, although supervisors noted a shortage of recovery nurses.

The panel were informed that anaesthetic input on the trauma list was always provided by a lone consultant anaesthetist. The panel heard that the sometimes the anaesthetist raised issues in relation to paperwork, which could lead to delays while these were resolved. It was reported that there did not appear to be a trauma lead from an anaesthetics perspective in terms of which cases should or should not be cancelled.

All doctors in training highly valued the work of the Trauma Coordinators in the department, who were described as brilliant, and it was perceived that the Trauma Coordinators were impacted by the same issues faced by doctors in training in terms of theatre efficiency. The panel heard that doctors in training were conducting an audit of the number of cancelled operations, which the Trauma Theatre team had not been informed of. It was reported that a digital form had been created for data collection, as the initial data collected from theatre software allegedly contained inaccurate times inputted by the theatre team.

The panel noted comments from the supervisor group suggesting that changes to operating practices during the pandemic, such as the move to morning and afternoon lists, may have contributed to some of the issues raised, however the panel noted a comment from the supervisor group which indicated that doctors in training being made to feel uncomfortable had predated this. In response to a question, supervisors confirmed concerns around cultural issues had been escalated within the Trust.

The panel heard that due to the known cultural issues, supervisors would sometimes remain in theatre with a doctor in training for cases which otherwise would have been deemed appropriate for the doctor in training to be left with. It was recognised that this compounded the issue of insufficient access to trauma training opportunities (see domain five). Supervisors viewed every trauma list as a training list, in which the level of involvement of the doctor in training would vary depending on the complexity of the case. It was suggested that the anaesthetist may sometimes appear unhappy about a case being a training opportunity and the panel heard that the supervisor would discuss with the anaesthetist to understand their concerns in relation to this.

The Trust described actions taken by the department in response to the concerns, which included one to one conversations around behaviour, collection of data by the clinical lead to analyse and present to the theatre team, and planning for the induction programme for core and higher doctors in training in T&O to include a session to meet the Trauma Theatre team. Trust representatives reported that sessions with the Freedom to Speak Up Guardian had been arranged on two occasions however no doctors in training had attended, despite efforts to release doctors in training from rostered commitments. However, when doctors in training were asked whether they had had the option to attend a session with the Freedom to Speak Up Guardian, they indicated they had not been released from their clinical activities.

The Trust acknowledged that the Trauma theatre team at WHH was short staffed and under pressure. The Trust explained that a number of theatre team members had left to work at the EOC, which was also highlighted by doctors in training and supervisors. The panel were informed that currently posts in the theatre team at WHH were filled and short staffing within the theatre team was generally attributable to sickness, however the Chief Medical Officer added that work was planned to review theatre staffing, and a proposal to increase establishment was currently subject to a business case.

When the Trust were asked whether there may be systemic factors influencing behaviours in theatres, it was recognised that there were some Trust-wide cultural issues and the panel heard that the Trust were participating in a culture and leadership programme. The panel heard that approximately 120 ‘change champions’ from a range of professions had been identified as part of the programme, which was currently in the diagnostic phase. It was anticipated this programme of work would take around two years. **See mandatory requirement reference MR-TO5.**

Culture of cross-site working and learning from adverse events

Doctors in training perceived there to be some animosity and rivalry between the T&O consultants from the WHH and QEQM sites. In response to direct questions, it was suggested that some consultants would openly speak badly of those at the other site and that doctors in training who had previously worked at QEQM may be treated with a degree of suspicion upon starting work at WHH. **See mandatory requirement reference MR-TO6**.

The panel were informed that the revision arthroplasty and audit meetings were cross-site meetings. When asked if a blame culture was apparent [in light of comments above], doctors in training indicated this had not been observed given the content of the meetings. Doctors in training valued the presentation and discussion of audits, however in terms of the Morbidity and Mortality (M&M) aspect it was reported that only a very small number of cases were discussed and there was limited understanding of the figures which were presented. It was perceived that although there was occasional learning to be gained, the meeting did not function in a way that would be considered usual practice for an M&M meeting. **See mandatory requirement reference MR-TO7.**

Patient Safety

The Trust confirmed that there were two named Patient Safety Specialists within the Trust and, at Board level, responsibility for Patient Safety was shared between the Chief Medical Officer and Chief Nursing and Midwifery Officer.

Equality, diversity and inclusion

When asked if they were aware of the role of the Equality, Diversity and Inclusion (EDI) Lead within the Trust, no doctors in training or supervisors present reported being aware of this role. The Trust confirmed that the EDI lead remained in post and had been involved in some faculty development days. **This will be linked to existing mandatory requirement MR-TW3 issued at previous quality intervention.**

Overall satisfaction

When doctors in training were asked if they would recommend the department to a friend or family member who needed treatment, no overall affirmative responses were heard and there was an indication that this might depend on the treatment required.

Supervisors noted that many previous doctors in training at the Trust had returned as consultants and viewed this as an indicator of their satisfaction with the quality of training received. When current doctors in training were asked if they would consider returning to work in the Trust as a consultant, responses were mixed. Some referred to concerns previously outlined in relation to the reliance on RMOs and the potential implications for patient care, however some saw potential for change.

Quality Domain 2: Educational Governance and Commitment to Quality

Prior to this review, the panel were aware of a specific incident which had raised concern regarding the Trust's protocols and governance arrangements in the event of a doctor in training being involved in an alleged safeguarding incident. The Trust referred to this incident in their presentation and explained that a lessons learned report, commissioned by the Chief Medical Officer and led by the Head of Employee Relations, had resulted in a change in existing policy to require the involvement of the Director of Medical Education in any decision around exclusion or restriction of a doctor in training, and that decision making should follow a risk-based approach.

In response to a question, the panel heard that the amended policy had been subject to a governance process and was now being shared. It was reported there was now a clear process

in place with the safeguarding team and Heads of Departments, however the Trust acknowledged that further work was required to instil this knowledge more widely within the organisation, ensure universal compliance with safeguarding training and promote understanding of how safeguarding roles and responsibilities in a leadership role differ from those in a clinical role.

When asked about the Local Faculty Group, doctors in training confirmed they did not have a representative who attended; it was reported that no one had been asked to do so. **See mandatory requirement reference MR-TO8.**

Quality Domain 3: Developing and Supporting Learners

Clinical supervision

The panel heard that investigation of a specific incident involving a doctor in training had led to concerns regarding supervision within on-call and outpatient clinic settings and that changes in process regarding supervision of clinics had been put in place as a result. The panel were informed that the associated draft Standard Operating Procedure had not yet been finalised; it was suggested that the changes had not been universally accepted within the department. **See mandatory requirement reference MR-TO9.**

The panel noted a reference from the supervisor group to a situation where a doctor in training had apparently been unsupervised in clinic for several weeks; it was reported that a consultant had been present in the next room and had been approachable for support. No concerns regarding clinical supervision in clinics were raised by doctors in training during the review; it was reported that generally the support and training offered by consultants in the department was very good. The Trust noted responses in their internal survey had been universally positive with regards to quality of clinical supervision.

The Trust confirmed that clinics were cancelled in the event that a ‘junior trainee’ (ST3-6) would be unsupervised; for ‘senior trainees’ (ST7-8) clinics could take place only if there was a named consultant supervisor present in the building. The Trust explained that ST3-6 doctors in training had expressed concerns around missed educational opportunities when their named clinical supervisor was away, in response the Trust had surveyed doctors in training to seek their preferences regarding alternative educational opportunities in this situation. The panel heard that doctors in training had been given the choice of clinics or theatres in a supernumerary capacity, which were then rostered. In response to a question, doctors in training suggested that being supernumerary in theatre would work well where core and HST doctors were paired together as they had different training needs, however it was perceived that it could be more difficult if two HST doctors were rostered together on the same list.

Induction

The Trust reported that the departmental induction checklist had been reviewed and revised.

The panel were informed that ST3 doctors in training were required to attend a two-day ‘Reg Ready’ course organised by the School of Surgery, the timing of which resulted in them missing Trust and departmental induction with their peers. This issue was raised by both the Trust team and doctors in training; the latter described the consequences of missing the main induction, which included a limited and lower quality hospital induction lasting up to 15 minutes, no

induction to the EOC, and being required to start work without an ID badge. The panel confirmed this would be addressed by the KSS School of Surgery.

Quality Domain 4: Developing and Supporting Supervisors

Time for educational roles

The Trust reported that consultants were job planned for their roles in the teaching programme. Regarding time for educational supervision, the panel were informed that time was allocated for the supervision of non-training doctors as well as doctors in training. Supervisors expressed that they required more time in their job plans for educational supervision. The panel heard several examples which indicated that supervisors were not allocated the agreed tariff for educational supervision of 0.25PA per doctor in training. It was noted that some consultants were responsible for supervising trainee Surgical Care Practitioners (SCP) as well as surgical doctors in training. Supervisors perceived that the role of SCPs in the department should enhance training opportunities for doctors in training. **See mandatory requirement reference MR-TO10.**

In response to a question, the Clinical and Education Lead within the department confirmed they felt well supported in their leadership role. The panel heard that time for the educational lead role was not job planned.

Quality Domain 5: Delivering Programmes and Curricula

Access to training opportunities to meet curriculum requirements

The Trust highlighted that logbooks demonstrated that doctors in training had gained extensive operating experience in the department, and this had correlated with feedback from the internal focus group. Doctors in training reported a good experience in terms of arthroplasty training opportunities. It was noted that the EOC provided ringfenced elective operating lists which doctors in training were able to access. The Trust explained that there was a minimum of four arthroplasty cases listed each day at the EOC; with alternate weeks of high volume, low complexity lists and complex long-wait lists, and doctors in training were exposed to both types of list.

However, doctors in training expressed concerns around access to sufficient trauma training opportunities, particularly at ST3 level for which trauma experience is a priority in terms of curriculum requirements. The panel heard that doctors in training and ‘junior’ Trust grade doctors at WHH had access to an average of one half-day of trauma experience per week, however at an individual level this was reported to have ranged from one half-day per fortnight to one day per week. The panel heard this contrasted with experiences at the QEQM which was reported to provide significantly greater exposure to trauma training opportunities, despite the lower intensity and number of admissions.

The panel heard that rotas had not been adjusted to increase exposure to trauma training opportunities at ST3 level at WHH. Doctors in training perceived that the department was aware that curriculum requirements varied at different training levels, however indicated that curriculum mapping had not taken place. The panel also heard there was variability between consultants in terms of the training offered and noted feedback which indicated that there was an individual consultant who appeared reluctant to assign cases on their list to doctors in training. It was explained to the panel that the fixed rota design for consultants in the Trust

meant this could impact on training opportunities on a weekly basis. **See Immediate Mandatory Requirement reference IMR-TO2.**

The panel heard that the virtual fracture clinic provided a good training opportunity and doctors in training had the opportunity to attend this. Comments were noted indicating concerns around inappropriate referrals from the Accident and Emergency (A&E) department at times; this was perceived by doctors in training to be an issue common to any organisation that offered a virtual fracture clinic and the importance of education to support the A&E team in their initial assessments was recognised.

The panel heard positive feedback regarding access to core training opportunities in the department this year; it was recognised this may have been influenced by the lower than usual number of doctors in training at this level in the department this year.

Teaching

The Trust reported that changes in clinical commitments related to the opening of the EOC had impacted on the organised teaching sessions which had previously taken place on Friday mornings. The panel heard that the teaching programme had been organised on a four-week rota, including a journal club, and all consultants had previously been able to take part. However, the Trust explained it was now difficult to ensure that all doctors in training and consultants were available at the same time to participate in a formal teaching programme.

Doctors in training raised similar concerns about the lack of departmental teaching since the EOC had opened. The panel heard a perception that in addition to some consultants now being unavailable on Fridays, there were some who were not willing to teach.

The panel were informed that doctors in training had identified slots where they could attend teaching without compromising their access to other training opportunities and the Trust were aiming to reinstate formal teaching on Wednesday afternoons. **See mandatory requirement reference MR-TO11.**

The panel heard that the educational value of the trauma meeting varied depending on the consultant present. It was reported that although some consultants would quiz the doctors in training on the cases presented, most of the time there was limited discussion of the cases. This was considered to be a missed educational opportunity, particularly in terms of exam preparation. The panel heard there was scope to include more teaching at this meeting given the relatively small number of post-take patients. This was attributed to the structure of the on-call service which ensured a dedicated on-call consultant was available during the day, therefore all new admissions were seen during the day and only patients admitted overnight were on the trauma meeting list. **See recommendation.**

Quality Domain 6: Developing a Sustainable Workforce

This domain was not specifically discussed, however mandatory requirement reference MR-TO3 is also relevant to this domain (standard 6.3).

Requirements

Immediate Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
IMR-TO1	The panel heard there were occasions where night locum 'SHO' doctors were consenting patients inappropriately.	The panel required the Trust to provide assurance that the practice of RMOs consenting any patient would stop immediately, with appropriate safeguards put in place. This assurance was required by 4 August 2023.
IMR-TO2	The panel heard that the department did not provide access to sufficient training opportunities to achieve curriculum requirements in trauma at ST3 level.	The panel required the Trust to adjust timetables in order to maximise exposure to trauma theatre to achieve required numbers of trauma cases by the end of the ST3 rotation. Evidence that this had been actioned was required by 4 August 2023.
Requirement Reference Number	**Progress on Immediate Actions**	**Required Action, Timeline and Evidence**
MR-TO1	The Trust confirmed the following on 4 August 2023: • the practice of consent by locum 'SHOs' had stopped • communications were sent via a range of routes to all doctors in the department asking for the practice to be stopped and outlining the new process. • spot-check audit is being undertaken to ensure the process is embedded. • the Trust will be implementing consent training using Ortho Consent and will incorporate this into teaching programme for all junior doctors.	The Trust are required to share the outcome of the spot-check audit to evidence that inappropriate practice with regards to consent has now stopped. This evidence is required by 1 December 2023.

MR-TO2	It is recognised that there are no ST3 doctors in training in this department until October 2023. The impact on individual progress with curriculum requirements associated with this concern will be managed via the School of Surgery. The Trust confirmed an appropriate rota will be put in pace for the ST3 starting in October to ensure exposure to trauma theatre is achieved.	The Trust must plan rotas to ensure that future ST3 doctors starting work in the department have sufficient access to trauma theatre opportunities to meet curriculum requirements. The panel recommend that ST3 doctors should be prioritised for trauma theatre lists and be rostered for at least three theatre sessions (1.5 days) per week. A copy of the proposed ST3 rota is required by 1 December 2023.

Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
MR-TO3	The panel heard concerns about the reliance on RMOs to provide out of hours cover and the associated impact on the working hours of the on-call HSTs who were frequently called overnight to provide support.	The Trust are required to review the hours worked by on-call HSTs to ensure these align with contracts and promote the use of exception reporting to monitor this. Rotas must be reviewed to ensure that HSTs are not rostered to work beyond the end of the trauma meeting on the day following their on-call shift. A diary card exercise should be completed and the outputs of this shared with NHSE to evidence this requirement. The Trust should consider alternative approaches to provide out of hours cover which do not rely solely on doctors, including but not limited to the Hospital at Night model, Physician Associates and Surgical Care Practitioners. Evidence is required by 1 December 2023.

MR-TO4	The panel heard that doctors in training may sometimes be required to review inpatients at WHH before travelling to the EOC. The panel considered the travel between sites during sessions to be an inappropriate use of training time.	The Trust must monitor how often doctors in training are required to travel between sites during sessions and review rotas accordingly to avoid doctors in training being required to travel between sites during sessions. The panel recommend that the Trust consider a Consultant of the Week model to support this and enhance continuity of care for patients. Evidence should be provided in the form of a rota outlining arrangements for ward patient cover by 1 December 2023.
MR-TO5	The panel heard concerns regarding the culture within trauma and orthopaedic theatres at WHH, which was reported to impact on efficiency and on patient and training experiences. The panel noted an apparent lack of joint governance meetings with theatre and anaesthetics input where theatre efficiency and other relevant issues could be discussed.	The Trust are required to take action to address the concerns raised. Director level input across theatres and multi-professional intervention, with a focus on team working, is suggested. Development of a multi-professional governance model should also be considered. The Trust must provide an update on the actions taken and planned to address the concerns by 1 December 2023.
MR-TO6	The panel heard reports of perceived animosity and rivalry between the T&O consultants from the WHH and QEQM sites, which was reported to impact on the treatment of doctors in training.	This matter must be brought to the attention of the Trust's Chief Medical Officer (or nominated deputy) to take the appropriate action. An update on the findings of any investigation and any actions planned or undertaken is required by 1 December 2023.
MR-TO7	The panel heard that adverse events were not discussed openly at the Morbidity and Mortality meeting.	The Trust are required to undertake an urgent review of this meeting to ensure this is fit for purpose. An update on the outcome of this review is required by 1 December 2023.
MR-TO8	The panel were informed that there was no nominated Trauma and	The Trust must ensure that Trauma and Orthopaedic Surgery doctors in

	Orthopaedic Surgery doctor in training representative for the Local Faculty Group.	training are represented at the Local Faculty Group meeting via a nominated representative. A copy of the next LFG meeting minutes is required to evidence this by 1 December 2023.
MR-TO9	The panel heard that the Trust had identified concerns regarding supervision within on-call and outpatient clinic settings and that changes in process regarding supervision of clinics had been put in place as a result. The panel were informed that a Standard Operating Procedure (SOP) was currently in draft but had not yet been universally accepted within the department.	The Trust must ensure that ST3-6 doctors in training do not undertake clinics unsupervised, and that appropriate measures are put in place if ST7-8 doctors in training are unsupervised in clinic, in line with KSS School of Surgery expectations set out in the Bone School document written by and circulated by the KSS T&O Training Programme Directors and approved by the Head of School. The Trust must provide a copy of the ratified SOP relating to this and monitor via LFG feedback that this is being implemented by 1 December 2023.
MR-TO10	The panel heard examples where supervisors had not been allocated time in their job plans for educational supervision in line with agreed tariff.	The Trust are required to provide evidence that all named educational supervisors are allocated time in their job plans for this role in line with the agreed tariff of 0.25PA per doctor in training by 1 December 2023.
MR-TO11	The panel heard there was a lack of regular organised departmental teaching since the opening of the Elective Orthopaedic Centre.	The Trust are required to ensure that doctors in training can access organised departmental teaching on a weekly basis. A copy of the teaching programme and attendance records over a three-month period is required to evidence this by 1 December 2023.

Recommendations

Recommendations will not be included within any requirements for the placement provider in terms of action plans or timeframe. They may however be raised at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Related Education Quality Framework Domain(s) and Standard(s)	Recommendation
Domain 5	The panel recommend that the Trust reflect on how the trauma meeting is conducted to optimise its potential as a learning opportunity.

NHSE Education Quality Domains and Standards for Quality Reviews

Quality Standard	Education 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.	MR-TO5 MR-TO6
1.2	The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	
1.3	The **organisational culture** is one in which all staff are treated fairly, with equity, consistency, dignity and respect.	
1.4	There is a **culture of continuous learning**, where giving and receiving constructive feedback is encouraged and routine.	
1.5	Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users. • **Patient safety discussions**	IMR-TO1
1.6	The environment is one that ensures the safety of all staff, including learners on placement.	
1.7	All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences. • **Freedom to Speak up Guardians** • **Survey intelligence including GMC NTS/NETS/PARE/GoSWH etc.**	
1.8	The environment is sensitive to both the diversity of learners and the population the organisation serves.	
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. • **Programme Review trainee representation discussions** • **Learner Educator trainee representation discussions**	
1.10	There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	MR-TO7
1.11	The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.	

	• **Facilities** • **IT provision** • **Library and knowledge services**	
1.12	The learning environment promotes multi-professional learning opportunities. • **Multi-professional discussions around opportunities**	
1.13	The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	

Quality Standard	Education 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. • **GoSWH discussions i.e. Junior Doctor Forum/Trainee Led Huddle**	
2.2	There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level. • **Discussions about racial discrimination/undermining – Trust engagement**	
2.3	The governance arrangements promote fairness in education and training and challenge discrimination • **Discussions about racial discrimination/undermining – promotion and actions within Trust**	
2.4	Education and training issues are fed into, considered and represented at the most senior level of decision making.	MR-TO8
2.5	The placement provider can demonstrate how educational resources (including financial) or allocated and used.	
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. • **SAR**	

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. • **Good practice discussions**	
2.8	Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including NHSE and education providers).	

Quality Standard	Education 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.	
3.2	There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	
3.3	The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	
3.4	Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	
3.5	**Learners receive clinical supervision** appropriate to their level of experience, competence and confidence, and according to their scope of practice.	MR-TO9
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.	
3.7	Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional standards, and learning outcomes.	
3.8	Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	
3.9	**Learners receive an** appropriate, effective and timely **induction** into the clinical learning environment.	
3.10	Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	
3.11	Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	

Quality Standard	Education 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.	
4.2	Formally recognised supervisors are appropriately supported, with **allocated time in job plans**/ job descriptions, to undertake their roles.	MR-TO10
4.3	Those undertaking **formal supervision roles are appropriately trained** as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. education providers, NHSE).	
4.4	Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	
4.5	Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.	
4.6	Clinical supervisors are supported to understand the educational needs (and other non-clinical needs) of their learners.	
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.	

Quality Standard	Education Quality Domain 5 Delivering Curricula and Assessments	Requirement Reference Number
5.1	Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	MR-TO11
5.2	Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	
5.3	Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.	
5.4	Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	
5.5	The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	
5.6	Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions required to meet curriculum requirements.	IMR-TO2 MR-TO3 MR-TO4

Quality Standard	Education 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.	
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 provider 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 and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.	

Report Approval

Report Completed by	Sarah Stanbridge, Quality Project Officer
Review Lead	Professor Jo Szram, Postgraduate Dean
Date signed	25 September 2023

NHSE Authorised Signature	Professor Jo Szram, Postgraduate Dean
Date signed	25 September 2023

Final Report submitted to organisation	16 October 2023