Health Education East of England

| School of Anaesthesia<br>Visit to Colchester Hospital University NHS Foundation Trust<br>Executive Summary<br>14th October 2013 | |
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| **Deanery representatives:** | Dr Simon Fletcher, Head of School of Anaesthetics, HEEoE<br>Dr Alys Burns, Deputy Postgraduate Dean, HEEoE<br>Dr Nigel Penfold, Quality Advisor for School of Anaesthetics, HEEoE<br>Dr Philip Hodgson, Quality Advisor School of Anaesthetics, HEEoE<br>Dr Peter Brodrick, Head of London Academy of Anaesthesia |
| **Trust representatives :** | Dr Timothy Howes, Director of Medical Education<br>Dr Joe Adams, Consultant in Anaesthesia (is he the CD?)<br>Dr Lajos Zsisku, Consultant in Anaesthesia, College Tutor<br>Dr Tony Elston, Associate Medical Director<br>Sharon Shirtcliff, Director of HR<br>Sharon Wyatt, Education and Development Manager |
| **Number of trainees & grades who were met:** | 6 core trainees (2 CT1, Anaesthesia, 1 CT2, 1 each CT1-3 ACCS)<br>3 ST trainees (2 at ST3, 1 at ST4)<br>ST4 retaking Final FRCA and undertaking 3/12 ICM |

**Background and Purpose of visit :**

Colchester is a busy District General Hospital with approximately 700 beds and 4000 deliveries.
The regional vascular service, major general and urological oncology all provide excellent training opportunities.
The Critical Care is relatively new, well equipped and staffed by a separate consultant rota.
There are eight core anaesthetic and 2 ACCS post, and capacity for 4 ST3+ trainees. There is also an F1 post based in anaesthetics and an F2 post in critical care. Core training in anaesthetics was repatriated from London to the East of England from August 2012, with a resultant increase in novice trainees starting at the Trust.
This visit was undertaken as part of a planned programme of School visits but prioritised due to nine Red Outliers from GMC Trainee Survey 2013, and anxieties identified through School surveys, both at Core level (Anglia) and ST (North Central London).
Colchester has also been under scrutiny through a mortality review and visited as part of the Keogh Review Risk Summit process. The impact of this process on education and training was uncertain.

**Strengths:**

All trainees interviewed were very happy with the support, training and experience they were receiving. The department and hospital was friendly and there were no reports of bullying of undermining.
Specifically:
Core Training

- School induction (at Chelmsford) was good
- Consultant support was appropriate at all times both in theatres and critical care
- None felt exposed or out of their depth
- 1:1 teaching reported as excellent
- ICU and Obstetrics delivered in dedicated 3/12 blocks
- ACCS trainees reported good experience and support in both AM and EM
- Working hours and rotas compliant

- Excellent Educational support
- No problem with study leave
- Weekly teaching programme, usually freed to attend

ST Training

- Similar reports about induction
- Clinical exposure good, appropriate workload
- EWT compliant
- Good supervision in and out of hours
- Good educational supervision
- Handover formal
- Core trainees well looked after, never exposed
- Overall satisfaction high with general positive feedback

High risk surgery had been moved from isolated theatre to main theatre block, a risk that had been identified at the last visit.

**Areas for development:**

It became clear that many of the issues identified from the GMC and our surveys were related to the high influx of CT1 trainees (7) in August 2012. This group, now CT2, were less happy than the other training groups. The tensions this created within the department were picked up by the trainees.
Specific issues included:
Core Training

- Posts initially un-banded, since reversed
- 6-8 months to complete initial achievement of competencies in some of 2012 cohort – now probably resolved (only 2.5 months into CT1 at time of visit)
- Trust and Departmental induction superficial and unstructured
- Local teaching programme not thought to reflect training needs and more about what trainers enjoyed delivering. Trainee input to restructuring the teaching programme had not been felt to be valued.
- Trainees on ICU not released for training
- A perception that not all theatre cases after 10pm were emergencies
- A tendency to over supervise more experienced trainees
- Not all consultant staff understood the training needs of ACCS trainees
- Trainees all have different educational supervisors, some of which provided better support than others in relation to curricular requirements and engagement with the Royal College of Anaesthetists e-portfolio.

ST Trainees

- Also recognised the pressures due to influx of CT1
- Many rota gaps, filled by locums
- Local and regional teaching primary FRCA orientated and of limited value to ST trainees, unless ST trainees actually delivering the teaching
- Spend too much time in ICU

| **Significant concerns:** |
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| There were no significant concerns identified |

| **Requirements:** |
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| There are no specific requirements but the following recommendations merit full consideration and implementation. |

**Recommendations:**

1. The Trust and Department should review their induction processes to ensure that they are relevant, appropriate and have sufficient detail.
2. Teaching programme should be reviewed to ensure a better match to curriculum requirements. The content of local teaching is not really relevant for ST trainees but they should be more involved with its delivery. We recommend that a separate, monthly regional programme be developed for ST (final FRCA) teaching in conjunction with other regional hospitals.
3. A deputy to the College tutor should be considered by the department to support succession planning and specifically support a review of the formal teaching programmes at both core and ST levels.
4. We recommend that the number of educational supervisors be reduced so that trainees are concentrated among fewer experienced trainers. This is particularly relevant for ACCS trainees.
5. It is clear that there are significant difficulties filling the on call rotas. This is not just a service issue as out of hours work does impact on day time training experience. We would support the Trust in their review of out of hours cover and activity after 10pm and consider whether this might be deliverable as a consultant only service. This model works in many DGHs and frees a tier of training.
6. Working with some degree of autonomy is an essential part of anaesthetic training. As core trainees gain more experience they should be able to work, on occasion, with local supervision. It would be expected that ST trainees deliver some non-emergency service. Who, when and what is the domain of an experienced training department.

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| **Timeframes:** | **Action Plan to Deanery by:** | 16 December 2013 |
| | **Revisit:** | 3 years |

**Head of School: Dr Simon Fletcher** **Date: 28.10.2013**

**Deputy Postgraduate Dean: Dr Alys Burns**