Health Education East of England

School of Anaesthesia Visit to Cambridge University Hospital NHS Foundation Trust Executive Summary Date of visit; Monday 16th March 2015	
Deanery representatives:	Dr Simon Fletcher HOS, EOE Dr Christopher Sharpe TPD, Anglia Dr Nicola Barber, Deputy Regional Adviser RCoA Dr Katrina Barber, Trainee Representative
Trust representatives :	Dr Arun Gupta, Director of Medical Education Dr Anita Patil, College Tutor Dr Megan Jones, College Tutor Dr Rowan Burnstein, Clinical Director, Anaesthetics Dr Jon Coles, Consultant Dr Claire Williams Consultant Mrs Sue East, Medical Education Manager
Number of trainees & grades who were met:	1 ACCS CT2 15 ST3,4,7 trainees

Purpose of visit :
This was a scheduled revisit to review progress against recommendation following visit 24th Feb 2014 Action plan updated had been received and reviewed prior to the visit There were no new concerns from the 2014 GMC trainee survey Dr Anita Patil presented an update of the Trusts actions and progress against the 2014 recommendations and issues were fully discussed before the trainees were interviewed. The review team would like to thank the anaesthetic department and, specifically Drs Patil and Jones, for their continuing support for training and their response to the issues identified in the previous visit

Strengths:
Those listed in the 2014 report were all supported. In summary Addenbrookes is an excellent, if challenging place to train. Clinical workload is stimulating and diverse. The department is friendly and supportive with no reports of bullying of undermining. Trainees generally worked within their capabilities

Areas for development:
There were no new concerns raised so the visitors reviewed those listed in the 2014 report. For clarity they are reproduced below followed by a summary of the progress/current situation

Significant concerns:
See below

Requirements:

1. The culture of list overrunning has many disadvantages and trainees should not be expected to routinely service these. This needs to be addressed in the wider context of the provision of theatre services.

   List overruns were monitored for a couple of months last year. Although this is not an uncommon event data suggests that trainees are rarely directly involved.

   The trainees themselves were happy that they were not routinely expected to support overrunning lists. They all accepted that it was an inevitable occasional event.

   Comment and recommendation;

   We are happy with the action taken here. We recommend that monitoring continues to be undertaken.

   Some lists support very long surgical procedures and the use of the on-call trainee, particularly in Neurosurgery, to finish these lists is less than ideal. Support for extended day working would better be addressed through consultant job planning

2. A process should be put in place to ensure that all those working in isolation receive adequate breaks.

   All consultants were emailed to flag this issue and trainees were also contacted and notified that it was their responsibility to request rest breaks. Local monitoring has not identified an ongoing problem.

   Comment and recommendation;

   There is considerable variation in practice here with some consultants proactive and others taking no action.

   Where trainees have requested breaks there have been no issues and most felt this was not a major problem.

   Generally we are happy that this is not a significant problem. Clearly some consultants will need reminding of their responsibilities. We are clear that the onus for providing breaks resides with the administrative consultant and the onus is not on trainees to request these.

3. A review of emergency theatre provision is essential from both a service perspective but also in the context of the impact on training.

   The Trust feels this is an operational issue and a piece of work is underway looking at emergency provision. If there is significant impact on training then we will continue to flag this. We were informed that there are as many as 6 day time emergency theatres, fully catering for clinical needs. In reality a number of these theatres are 'virtual', supporting elective work routinely. There is no dedicated day time provision for renal transplantation and thus these are, on occasion, undertaken out of hours with obvious knock-on effects

   Trainees were happy that their training was not significantly compromised at this stage. We support the ongoing service review

4. The numerous duties of the second on call have real patient safety implications. There are no other areas where a single doctor is expected to run an HDU, staff an emergency theatre, trouble shoot across the rest of

the Trust and hold the Trauma bleep. This requires urgent review.

This issue provoked a long and comprehensive defence of the duties of the second on call and significant debate during Dr Patil's presentation. The change in evening duties of the Clinical Fellow, to allow a formal review of the OIR, is welcome. The School fully supports the development of senior trainees by the adoption of significant responsibilities. The trainees were clear that they welcomed this responsibility but equally clear that there were times when more proactive consultant support was necessary. Despite assertions to the contrary, they are frequently called to help out across the Trust, despite the presence of the Rapid Response Team.

In summary, although changes to the responsibilities of the Clinical Fellows have helped, we were unimpressed with the response to this issue; essentially a defensive justification of the status quo. We support trainee development and the adoption of significant responsibility. This occurs in many Trusts across the region. On call consultants must ensure that they are proactive in their support for these trainees. <u>This issue will remain under review</u>

5. A formal handover process must be put in place

In response to this requirement the department were able to outline the handover policy across the various areas of responsibility. In general theatres and the OIR this in trainee led with little or no consultant input. In Neuro trainee/consultant interaction is usually by telephone.

Trainees confirmed the formal handover in both Obstetrics and Critical Care and the telephone interaction in Neurosurgery. General handover is unsatisfactory. Time and place is not determined and thus a formal handover may not occur. The situation with the OIR remains unchanged. The citing of a 10 year old paper describing the practice of an, essentially, cardiac unit is inadequate justification for current practice.

<u>This issue is not resolved.</u> A formal handover is essential in general theatres. Defining a time and place would facilitate this. Although the second on call is now able to review the OIR this should be more structured.

6. Consultants must adopt a proactive approach to their on call duties and should physically ensure that there are no issues before going home

We were assured that this was department policy and that all had been reminded of their responsibilities.

We were unclear of the relevance of requesting the trainees to be proactive.

Despite the above assurances the trainees reported that the practice of consultants in this area had not changed

<u>This is an unresolved departmental governance issue</u>

7. Paediatric pain rounds at weekends should be undertaken by the on call paediatric anaesthetist.

Monitoring, we were informed, had not identified a significant problem, with few epidurals in place at the weekends.

Trainees reported that they were often unable to assess these patients until late in the day due to other commitments

As this duty is not perceived as onerous we find the position of the paediatric group difficult to understand.
This requirement remains unresolved

Recommendations:

1. The anaesthetic induction process should be reviewed. It would seem sensible to consult the current trainees for their views on the practicalities described above.

   A review of this, with trainee participation had been undertaken. All reported an excellent process in all areas except general Critical Care. This was haphazard and unstructured.

   We are happy with the actions taken here but the process in the JFU needs overhauling

2. A review of the formal teaching programme is encouraged, again in consultation with the trainees.

   This has been undertaken. All reported excellent teaching

   This issue is resolved

3. It is important not to overestimate the abilities of new trainees and this should always be considered. A reminder to supervising consultants at changeover times would seem indicated, and consideration given to allocation of duties during this initial period. The trainees should be encouraged to access the mentoring scheme that is offered.

   Again the department have been proactive here and all trainees were happy with their experience

4. It is not unreasonable in a major trauma centre for trainees to gain exposure to the acute management with the direct consultant supervision.

   Appropriate action has been taken here. Relevant experience can be reviewed at ARCP's and future visits

5. Minimise the splitting of time spent in key units

   This issue was discussed and there was general consensus that splitting units was unsatisfactory for both trainers and trainees. It was agreed that all major units would not be split in the future, including neuro and paeds and hopefully plastics and vascular

Timeframes:	**Action Plan to Deanery by:**	03/12/15
	Revisit:	

Head of School: Dr Simon Fletcher **Date:** 02/06/15

Deputy Postgraduate Dean: