School of Postgraduate Medicine Visit to
Clinical Pharmacology & Therapeutics Programme, Cambridge University Hospitals NHS Foundation Trust

Visit Report
23rd November 2016

| HEE (East of England Office) representatives: | Ian Barton- Head of School of Medicine  
Sue Agger - Senior Quality Improvement Manager  
Nigel Langford- TPD for CPT, HEE, East Midlands Office  
Alastair McLellan- GMC Enhanced Monitoring Associate  
Kevin Connor- GMC Education Quality Assurance Programme Manager  
Abigail Nwaokolo- GMC Educational Quality Analyst  
Wendy Kingston - Patient & Public Voice Partner (lay representative)  
Chris Wilkinson- Senior Clinical Advisor  
Aaron Braddy- Trainee Representative  
Catherine Moulsher - Quality Improvement Administrator |
| Trust representatives : | Jag Ahluwalia- Medical Director  
Arun Gupta- Director of Postgraduate Medical Education  
Pamela Todd- Deputy Director of Postgraduate Medical Education & Clinical Tutor  
Madhavi Vindlacheruvu- RCP College Tutor  
Kevin O’Shaughnessy- Training Programme Director for CPT  
Ian Wilkinson- Director of Cambridge Clinical Trials Unit  
Joseph Cherien- Clinical Pharmacology Educational Supervisor  
Alison Risker- Associate Director of Workforce  
Mark Manford- Divisional Director, Division D  
Ewen Cameron- Divisional Director, Division C  
Elizabeth Hunt- Associate Director of Operations, Division D  
Maria Mulrennan - Associate Director of Operations, Division C  
John Firth- Deputy Medical Director and Consultant Physician Nephrologist  
Louise Sharp- Specialty Administrator (Surgery)  
Chillien Hoang- Specialty Administrator (Medicine)  
Mary Archibald- Medical Education Manager |

Number of trainees met and grades: ST3+s: 6

Purpose of visit:
This was a GMC Enhanced Monitoring re-visit to the Clinical Pharmacology and Therapeutics Programme in the East of England, following a GMC Enhanced Monitoring Visit on 15th December 2015, which had identified ongoing concerns about curriculum delivery in the department with no concerns about patient safety and undermining. Following this visit, the Department provided a comprehensive action plan which appeared to address all of the requirements contained in the visit report.
However, the 2016 GMC Trainee Survey identified significant concerns with training in the Department, with the following negative outliers: overall satisfaction, adequate experience, feedback and supportive environment. The Department was a positive outlier for workload.

This visit was therefore focussed on exploring the concerns raised in the GMC national training survey (NTS) and also on reviewing the Trust’s progress with addressing the concerns reported following the visit on 15th December 2015 and, specifically, the following requirements:

- There must be a consultant on call rota and this must be readily accessible to all the trainees in the Department (and also to staff outside the Department)
- Service needs within the Department should be equitably allocated
- Trainees should continue to attend hypertension clinics, as the department has huge expertise in this area and these clinics provide excellent opportunities for learning about CPT in a clinical context
- For trainees in dual programmes, the CPT core curriculum should also be delivered in the context of their second specialty wherever possible. The trainers should work with the trainees to decide how this can be achieved. Examples might include the trainees completing pharmacology-related WPBAs with the CPT trainers on patients they have encountered in their dual specialty or the trainees delivering presentations at the monthly teaching sessions about pharmacology-related issues they have encountered in their dual specialty
- Trainees should not be expected to carry the on call bleep (although they should have the option to do so when they feel that doing so will provide good relevant learning opportunities). The bleep could be carried by the on-call consultant, the department’s nurse practitioner or the clinical fellow (who has a particular interest in hypertension)
- Trainees should have the opportunity of learning in an inpatient environment. The possibility of the CPT Department having its own inpatient beds should be explored. Alternatively, the trainees could have a role in the management of inpatients in the acute medicine department during the periods when one of the CPT trainers is working in acute medicine
- Training should be divided into blocks during which the trainees are allocated to either CPT or their dual specialties (provided this is acceptable to the dual specialties). This is a specific trainee request and they should be consulted about how they feel this should be structured (e.g. duration of blocks and what should be the content of each block)
- There should be greater clarity about what the learning opportunities are that are available, which curriculum competences can be learnt from them and how they can be accessed. There is a School of Medicine-wide exercise currently ongoing led by the regional lead higher specialty trainee representative to do this in all specialties. The trainee representative in CPT is aware of this and should lead on delivering this requirement
- Each trainee should have a personal development plan which gives an indication of when he or she is expected to access specific training opportunities (e.g. Pharma attachment, research, clinical trials unit, toxicology, meetings of the Joint Drug and Therapeutic Committee, NICE, MHRA, LREC etc).
- All trainees should also be allocated time to attend the MPhil in Translational Medicine and Therapeutics course in Cambridge at least once during their training programme
- Where training in specific areas (e.g. toxicology) cannot be delivered in Cambridge, there should be easily available opportunities to access this elsewhere
- The GIM placements of the dual CPT/GIM programme should be reviewed in order to provide a range of training opportunities; these should include placements in a specialty in Addenbrookes with a significant GIM commitment (e.g diabetes and endocrinology) and a DGH placement in order
to provide experience of ongoing care

- The Department should set up a Faculty Group (see Trainers section of the School of Medicine pages of the website) to provide a forum where the trainers and trainees can meet to discuss any areas of concern and to continue to develop the training programme.
- A separate trainee forum should also be established to act as the “trainee voice”

And recommendation:

- The Trust should take advice from another CPT training Unit which has a track record of delivering high quality training and should consider entering into a formal buddying arrangement with that unit

### Strengths:

- The consultants are all very knowledgeable, approachable and supportive.
- The TPD, Kevin O’Shaughnessy, was singled out for special praise by all the trainees as someone who is seen as a solution finder who has succeeded in individualising the training of each trainee in the programme.
- The whole Department has been fully engaged with addressing the concerns identified in the previous visit and in the GMC NTS.
- Those trainees who were in post at the time of the first GMC enhanced monitoring visit to the Department described the learning environment in the Department as being unrecognisably better than it had been prior to that first visit.
- The trainees were very positive about the changes that have been made, particularly training in blocks, the availability of industry attachments and access to the MPhil programme.
- Many of these changes have come into full effect since the last GMC NTS. The trainees reported that, if the NTS were to be repeated now, their feedback would be much more positive.
- The trainees were all confident that there is now a clear pathway for them to meet most, if not all, of the CPT curriculum requirements within CUH – although, for some, it may be necessary to complete the toxicology competencies using another provider.
- The trainee who joined the Department since the last visit has had a full and relevant induction to the Department and is very clear how his dual Training Programme will be delivered.
- The presence of pharmaceutical companies on site gives exceptional access to a range of outstanding training opportunities, which are not so easily accessible in any other CPT training location in the country.
- The Department is attractive to trainees considering a career in CPT, with at least one trainee expressing an interest in applying for an ST3 post in CPT and GIM in the EoE in 2017
- Overall, the Department has the learning opportunities on site which give it the potential to be among the best training sites for CPT in the UK.

The following requirements have been fully met:

- There must be a consultant on call rota and this must be readily accessible to all the trainees in the Department (and also to staff outside the Department): This is available (although some trainees said that they were not always aware who the on call consultant was)
Service needs within the Department should be equitably allocated: This has been facilitated by the appointment of a clinical fellow and updating of the training programme to include defined blocks.

Trainees should continue to attend hypertension clinics, as the department has huge expertise in this area and these clinics provide excellent opportunities for learning about CPT in a clinical context. Trainees are rostered to attend general hypertension clinics during CPT blocks.

For trainees in dual programmes, the CPT core curriculum should also be delivered in the context of their second specialty wherever possible. The trainers should work with the trainees to decide how this can be achieved. Examples might include the trainees completing pharmacology-related WPBAs with the CPT trainers on patients they have encountered in their dual specialty or the trainees delivering presentations at the monthly teaching sessions about pharmacology-related issues they have encountered in their dual specialty. There is good evidence in the trainees' ePortfolios that this is occurring.

Trainees should not be expected to carry the on call bleep (although they should have the option to do so when they feel that doing so will provide good relevant learning opportunities). The bleep could be carried by the on-call consultant, the department’s nurse practitioner or the clinical fellow (who has a particular interest in hypertension). Currently, the departmental bleep is being carried for most of the time by the clinical fellow, who is now more confident than some of the trainees in managing acute referrals for CPT and hypertension-related advice. It seems disproportionately important to some of the trainees that they should not be asked to carry the bleep given the infrequency with which calls are received. However, all of the trainers, some more strongly than others, feel that not carrying the bleep is detrimental to training, because a valuable training opportunity is being lost.

Trainees should have the opportunity of learning in an inpatient environment. The possibility of the CPT Department having its own inpatient beds should be explored. Alternatively, the trainees could have a role in the management of inpatients in the acute medicine department during the periods when one of the CPT trainers is working in acute medicine. Trainees have yearly 8 week blocks in the acute medicine department, usually CPT trainers are the consultants responsible for acute medicine and are therefore available to supervise and train them.

Training should be divided into blocks during which the trainees are allocated to either CPT or their dual specialties (provided this is acceptable to the dual specialties). This is a specific trainee request and they should be consulted about how they feel this should be structured (e.g. duration of blocks and what should be the content of each block). This is now in place.

There should be greater clarity about what the learning opportunities are that are available, which curriculum competences can be learnt from them and how they can be accessed. There is a School of Medicine-wide exercise currently ongoing led by the regional lead higher specialty trainee representative to do this in all specialties. The trainee representative in CPT is aware of this and should lead on delivering this requirement. This is now in place.

Each trainee should have a personal development plan which gives an indication of when he or she is expected to access specific training opportunities (e.g. Pharma attachment, research, clinical trials unit, toxicology, meetings of the Joint Drug and Therapeutic Committee, NICE, MHRA, LREC etc). All trainees have a PDP and trainees now have monthly meetings with their educational supervisors to ensure they are meeting the targets in their PDP.

All trainees should also be allocated time to attend the MPhil in Translational Medicine and Therapeutics course in Cambridge at least once during their training programme. This is in place and some trainees are undertaking the MPhil.
Where training in specific areas (e.g. toxicology) cannot be delivered in Cambridge, there should be easily available opportunities to access this elsewhere. There are good opportunities for the whole curriculum to be delivered in house; if any trainee is unable to meet all of his/her curriculum requirements in the Department, arrangements will be made for the trainee to access the relevant learning opportunities elsewhere.

The GIM placements of the dual CPT/GIM programme should be reviewed in order to provide a range of training opportunities; these should include placements in a specialty in Addenbrookes with a significant GIM commitment (e.g. diabetes and endocrinology) and a DGH placement in order to provide experience of ongoing care. Appropriate training opportunities have been identified within CUH obviating the need for placements in other Trusts.

The Department should set up a Faculty Group (see Trainers section of the School of Medicine pages of the website) to provide a forum where the trainers and trainees can meet to discuss any areas of concern and to continue to develop the training programme. This is included as an agenda item in clinical governance meetings.

A separate trainee forum should also be established to act as the “trainee voice”. The specialty’s trainee representative meets regularly with his colleagues and they are confident in his ability to feedback their thoughts to the trainers (and of the trainers to respond).

The following recommendation has been followed:

- The Trust should take advice from another CPT training Unit which has a track record of delivering high quality training and should consider entering into a formal buddying arrangement with that unit. The Department has formed links with GSK, but this has a relatively small training programme; maintaining useful links with UCLH has proven difficult, owing to a number of CPT consultants having left or being about to leave UCLH.

Areas for Development:

- Relationships between CPT and some of the linked specialties, particularly allergy, should be improved. For example, there appear to be disagreements about how much time trainees should be spending in each specialty. Some trainees who are training in specialties which do not generally contribute to GIM on call rotas seem reluctant to recognise the importance of having a wide general knowledge of GIM in order to practice safely as a clinical pharmacologist.

- Trainees are currently able to choose when they do acute medicine blocks; this has resulted in two trainees doing acute medicine simultaneously which will limit training opportunities. Although monthly meetings between educational supervisors and trainees are occurring, the contents of these are not being consistently recorded in the trainees’ ePortfolios. It is important that this is done as, for example, it can be used as objective evidence to demonstrate that trainees are receiving an appropriate amount of support.

- ARCP Panels are currently held in February. As most trainees join the programme in August, this makes it difficult to assess trainees’ progress against the relevant year of training’s ARCP Decision Aid.

- At least one trainee has limited evidence of engagement with the CPT curriculum in his/her ePortfolio.
**Significant concerns:**

- There was a report of a single episode of derogatory comments being made about trainees during an educational meeting; the relevant educational supervisor has been reminded that it is not appropriate to behave in this manner and has made an apology.

**Requirements:**

- Derogatory comments about trainees should be recognised as unacceptable and should cease with immediate effect.
- The main period for holding ARCP Panels should be moved to July/August (although an ARCP Panel should be held in February 2017, with the next panel being held in July/August 2017).
- All educational meetings should be recorded in the trainees’ ePortfolios with immediate effect.
- All trainees should have an educational meeting at least six weeks before their planned ARCPs specifically to review their progress against the relevant year’s decision aid. Any outstanding curriculum requirements should be identified and trainees should be encouraged to meet these prior to their ARCPs. If a trainee is performing particularly poorly, the educational supervisor should follow the Trust’s and HEE EoE’s Trainee in Difficulty Policies and escalate any significant concerns if appropriate.

**Recommendations:**

- The consultant on call rota should be easily accessible to trainees and they should be reminded where to find it.
- Where there is a disagreement with a dual speciality about how the joint curriculum will be delivered or how time will be allocated between each speciality, there should be a meeting between the supervisors from each speciality and the trainee to resolve this. Where necessary, the Head of School will attend this meeting. Trainees should be reminded that their training number has come from the clinical pharmacology training programme.
- Each trainee should have a clear training plan for the year ahead. Within this, any attachments to acute medicine should be specifically timetabled, so that, unless there are very exceptional circumstances, only one trainee is allocated to acute medicine at any one time.
- Having had a period during which trainees have not held the departmental bleep, the trainers are unanimous in believing that a valuable training opportunity is being missed. The visiting team recognise that some trainees are reluctant to resume holding the bleep. However, given the strength of feeling of the trainers, the visiting team now believe that it is appropriate for there to be periods when all trainees in the Programme hold the departmental bleep. While carrying the bleep, trainees should receive a level of supervision appropriate to their expertise in managing the condition for which the patient is being referred. In order to deliver this supervision, it would seem sensible that trainees should hold the bleep during the period when they are assigned to acute medicine (as their supervising consultant in acute medicine will be a clinical pharmacologist, so appropriate advice will be readily accessible). There may be other opportunities for trainees to hold the bleep as well as periods when it is not appropriate for a trainee to hold the bleep (such as research blocks).
- The TPD should explore opportunities for trainees to train in other sites in the Region, such as NNUH. It is understood that a meeting with NNUH is already planned to discuss this. This should be discussed at the next STC meeting.
- The TPD should also explore opportunities to work more closely with other training programmes in the Midlands and East LETB. This should be discussed at the next STC meeting.
- Trainees should understand the importance of a wide knowledge of GIM if they are going to practice safely as a CPT consultant; in line with trainees in other Regions with individuals training solely in CPT, trainees should meet GIM commitments performed within the remit of standard CPT training as would be expected of a dual CPT/GIM trainee; this will be addressed at the trainees’ next ARCPs, which the Head of School of Medicine and a JRCPTB-nominated External Advisor will attend.
- The Department should consider whether it is appropriate to continue dual training programmes with specialties which do not traditionally contribute to the GIM on-call rota, such as dermatology and allergy. This should be discussed at the next STC meeting.
- The Department should consider whether it is appropriate to re-develop dual training programmes with specialties which align well with hypertension training, such as cardiology and renal medicine as well as other specialties which contribute to the GIM on call rota such as respiratory medicine. This should be discussed at the next STC meeting.

Decision of the Visiting Team:
- The Trust has met all the requirements of the previous visit.
- There are no concerns about curriculum delivery or patient safety in the Department.
- There was a single episode of an incident which might be perceived as undermining, but this has been satisfactorily resolved internally.
- The School of Medicine is able to recommend provisional approval of the ST3+ posts in the department for a further period of six months. If the outcome of the 2017 GMC NTS is satisfactory, this approval will be extended to the full period of three years.
- The ST3+ posts in the department will remain under enhanced monitoring by the GMC at least until the next GMC NTS in order to ensure that the improvements identified in this visit have been sustained; if they have been, GMC enhanced monitoring will cease.

Action Plan to Health Education East of England by:
- An action plan should be provided by 27th January 2017.

Revisit: Unless new serious concerns emerge, training in CPT will be reviewed as part of the next routine School of Medicine visit to the Trust as a whole. No GMC enhanced monitoring visit to the CPT Programme is currently planned.

Visit Lead: Ian Barton

November 2016