NHS
Health Education England

School of Anaesthesia Visit to Norfolk and Norwich University Hospitals NHS Foundation Trust Executive Summary Date of visit: 12th May 2016	
Deanery representatives:	Dr Helen Hobbiger – Head of EoE Postgraduate School of Anaesthesia and Associate Dean Dr Nicola Barber – Regional Advisor for Anaesthesia Dr Emily Simpson – Deputy Regional Advisor for Anaesthesia Dr Doug Bomford – Trainee Representative Mrs Brenda Purkiss – Lay Representative
Trust representatives :	Mr Richard Smith – Director of Medical Education Dr Manasi Bhagwat – College Tutor for Anaesthetics Dr Helen Goddard – College Tutor for Anaesthetics Dr Mike Irvine – Anaesthetic and ICM, Educational Supervisor Dr Rachael Morris – Anaesthetic Educational Supervisor Dr Debbie O'Hare – Anaesthetic Educational Supervisor Dr Jackie Raskovic – Anaesthetic Educational Supervisor Dr Christopher Sharpe – Consultant Anaesthetist and Training Programme Director Mrs Wendy Wood – Medical Education Manager Mrs Karen Crockett – Deputy Medical Education Manager
Number of trainees & grades who were met:	In total 10 trainees and 1 MTI doctor were interviewed: ACCS CT1 x1 (currently doing year of Anaesthesia/ICM) ACCS CT2 x2 CT2 x1 ST3 x2 ST4 x2 ST7 x2 MTI x1

Purpose of visit :

The Norfolk and Norwich University Hospital was visited as part of the rolling review of training in Anaesthesia in all Trusts in the East of England. The department was last visited in June 2012.

The 2015 GMC national training survey identified two red flag outliers for workload and feedback. This was against a background of one green flag outlier in the 2014 survey for induction.

Further detail used to inform the visit was supplied by the annual regional trainee survey and executive reports for the 2015 Dean's annual report to the GMC. Further information provided by the College Tutors on the day included a copy of the in house novice anaesthetist's handbook, a schedule for departmental induction, a copy of the teaching programme and minutes from faculty group meetings.

Strengths:

The Norfolk and Norwich University Hospital has a longstanding regional reputation for the excellent support and delivery of training. It was apparent after meeting with the DME and trainers that a strong training culture continues to feature in the trust. Recent changes in the structure of the Directorates has enhanced the educational clinical governance framework and reporting system.

- All trainees would recommend their post to colleagues.
- There were no reported incidents of bullying, harassment or undermining.
- No trainee reported any patient safety concerns. An isolated patient related episode was described. This occurred as a direct result of a gap on the on-call rota. No patient harm resulted and the department responded promptly to ensure this was a one off event.
- Departmental induction was described as appropriate and good.
- Novice trainees described a well structured induction period, where exposure was limited to a selected number of trainers and frequent group tutorials were used to provide knowledge in key areas.
- All novice trainees obtained their initial assessment of competency at an appropriate stage and had met with their Educational Supervisor (ES) prior to working out of hours.
- All trainees knew their ES and met with them regularly both formally and informally. The working knowledge of the ESs was described as good with all knowing the required learning objectives for the trainee's stage of training.
- All Anaesthetic ESs were receiving the recommended PA support for their role.
- All trainees were aware of the sequence of their training modules and all were receiving the RCoA minimum requirement of an average 3 supervised training lists/week.
- Senior Clinical Fellows and MTI doctors were also supported by an identified ES. This is considered an area of good practice.
- There were no significant barriers to getting work place based assessments or units of training signed off.
- No trainee described being asked to work beyond their level of competency.
- Levels of supervision are good with all trainees aware of who to call for assistance when working solo.
- The Department has regular faculty meetings to discuss training related issues. These are led by a senior trainee and attended by educators and trainees from all levels.
- The department has responded to recent trainee feedback regarding the rota. Changes have been made to the shift timings and daytime duty allocations. This has resulted in the identification of additional training time.
- The rota co-ordinator and college tutors work well together as a team to ensure all trainees have adequate exposure to their required training modules.
- Although the department uses internal locums to backfill rota gaps no trainee described feeling pressurised to do these additional shifts. The rota coordinator keeps a record of the number of locums each trainee undertakes so ensuring that this activity does not impinge on training time. No trainee cited this as a cause for not completing their training requirements.
- No trainee described difficulty in taking either annual or study leave.
- Trainees were not inconvenienced by overrunning lists and were receiving rest breaks.
- There are currently minimal late changes to allocated lists.
- Trainees were aware of the availability of post on-call rest rooms and knew how to book these.
- The handover rounds in Obstetrics were described as working well and the evening handover round in Critical Care was seen as good.
- Trainees were able to attend and present at the monthly Clinical Governance meetings.
- The interviewed MTI doctor has been working within the department for one month. He described a good introductory programme, had been allocated an ES who identified with him his required learning objectives and provided him with the appropriate RCoA documentation to guide his career development.
- The DME was quoted by the Tutors as being very supportive. He has recently been able to identify Trust funds to support trainees working in non-training non-substantive posts so to provide an equitable study leave budget to that made available to trainees. This is extremely noteworthy and considered to be area of best practice.

Areas for development:

- The trainee out of hours' rotas are onerous and under significant pressure. The service requirements necessitate the current 4 tier structure although there are presently insufficient numbers to support this. As a consequence, all rotas are now functioning as a 1:7. This is out of keeping with the current RCoA advice for trainees to work a maximum 1:8 rota to ensure sufficient training time. Rotas are supported by Consultants working extended days and backed up by 4 Consultant on-call rotas – General, Paediatrics, Obstetrics and Intensive Care Medicine.
- Gaps in rotas are currently filled by locums – both internal and external. When unavailable Consultants are acting down to backfill.
- Trainees described the out of hours' rotas as challenging but achievable. Some described the frequent shift changes as difficult but also acknowledged that individuals differ in their preference for rota patterns.
- The department has gained funding to support 4 Senior Fellows (post CCT) which would assist in easing the rota pressures. Unfortunately, recruitment is proving difficult with only one post filled and due to start in August.
- There is a disparity in the view of the in-house teaching programme. The Tutors described protected regular Tuesday afternoon teaching sessions with break out groups to address particular learning needs. The trainees described these sessions as ''not working'' with occurrence being patchy and not always targeted to their stage of training. Reasons for non attendance included on-call and days off but there was an additional sense that it may be related to the quality of the programme. The inference being that the trainee would learn more by undertaking a supervised list with a Consultant. See below.
- There was limited awareness of the regional teaching programmes. Core trainees appeared to have attended virtually none; pre-fellowship trainees described several instances of poor communication even for sessions occurring in-house; post fellowship trainees appeared to have the greatest knowledge and had attended some of the days. See below.
- The Critical Care Area has a combined, level 2 and 3, bed number of 20. There are significant longstanding pressures on these beds and plans are now in place to expand the unit. In the interim on 2 nights/week there are 4 overnight stay beds provided in the theatre recovery area. These beds are managed by the Critical Care team.
- Management plans for patients in intensive care were described as differing from day to day and were dependent on the Consultant in charge. Although this can be true for all Critical Care Units, this should be based solely on patient progress whereas the interpretation here was more down to a lack of continuity of care. Outcome figures for Norwich, as evidence by ICNARC (intensive care national audit and research centre) data, are known to be in keeping with other similar sized units and consequently this approach cannot be viewed as detrimental to patient care, although it does have the potential to confuse trainee learning.
- The Critical care trainee rota is a hybrid which combines those undertaking specific modular training and those working occasional ad hoc shifts to provide sufficient service cover. There have been recent attempts to ease staffing pressures with an expansion in Consultant numbers. It is understood that alternative work streams including advanced critical care practitioners (ACCPs) are also being looked at.
- The faculty tutor for ICM was not available for the visit (the date of which had been changed from that originally agreed), it is however necessary to ensure that he also has sufficient time in his job plan to meet the requirements of his role.

Significant concerns:

There is a one significant concern:

- The morning handover round in critical care was described as being dysfunctional. Trainees handover to each other whilst a separate Consultant and Senior Nurse handover takes place in the Consultant office. Trainees are not invited to the latter and viewed it as a potential patient safety issue due to the lack of continuity in care. Additionally, this represents a missed opportunity for feedback and learning. The unit is due to be included in the regional training programme for stage 3 ICM trainees.

Requirements:
• The in-house teaching programme should be reviewed. Trainee comments should be included in the plans and it would seem appropriate for this to be taken forward as an agenda item for the faculty meetings. The majority of sessions should be facilitated by a Consultant with particular reference to the level of the trainees attending especially around exam time. • In addition, there needs to be improved in house communications regarding the regional teaching programmes. In due course the new regional anaesthetic website hosted on the HEE EoE site should also assist with this. • The need for a formalised morning multi-disciplinary handover round should be urgently addressed.

Recommendations:
• The RCoA considers the undertaking of elective solo lists as part of the process for career development. All trainees working at intermediate and above level should, from time to time, have the opportunity to undertake elective list work with immediate distant supervision. In order to support this the trainers have identified the need for a named but non allocated Consultant who would be readily available to lend support. This individual would be identified on the rota as the 'floating black spot'. An additional benefit for this approach would be to enhance overall patient safety with skilled support available to all if needed. This approach would be considered an area of best practice. • The increasing requirements for service provision would indicate that staffing at all levels needs to be kept under review. The department is already considering alternative work streams including ACCPs and Physicians Assistants (Anaesthesia) in addition expansion at sub-consultant level (i.e. SAS doctors) could also be looked at.

Timeframes:	**Action Plan to Deanery by:**	18th July 2016
	Revisit:	3 years (subject to outcomes from national and regional feedback surveys)

Head of School: H Hobbiger **Date: 23rd May 2016**

Deputy Postgraduate Dean: