Health Education East of England

| School of Anaesthesia<br>Visit to Cambridge University Hospitals NHS Foundation Trust<br>Executive Summary<br>Date of visit: Monday 24th February 2014 | |
|---|---|
| **Deanery representatives:** | **Dr Simon Fletcher** – Head of Postgraduate School of Anaesthesia and Associate Dean<br>**Dr Alys Burns** – Head of Education and Quality for Secondary and Tertiary Care, Deputy Postgraduate Dean<br>**Dr Helen Hobbiger** – Regional Advisor, The Royal College of Anaesthetists<br>**Dr Christopher Sharpe** – Programme Director, Anaesthesia Regional Training Committee<br>**Dr Lorraine de Gray** – Regional Advisor for Pain Medicine, The Royal College of Anaesthetists<br>**Dr Maria de Rocio Ochoa-Ferraro** – Trainee Representative |
| **Trust representatives :** | **Dr Arun Gupta** – Director of Medical Education<br>**Dr Pamela Todd** – Clinical Tutor<br>**Dr Anita Patil** – College Tutor<br>**Dr Megan Jones** – College Tutor<br>**Dr Andrew Bailey** – Clinical Director of Anaesthesia<br>**Dr Jane Sturgess** – FTPD and Consultant Anaesthetist<br>**Dr Janet Pickett** – Lead Obstetric Anaesthesia<br>**Dr Claire Williams** – Educational Supervisor<br>**Dr David Ferrer** – Educational Supervisor<br>**Zoe Searle** – Medical Workforce Manager<br>**Mary Archibald** – Postgraduate Centre Manager<br>**Sue East** – Deputy PG manager |
| **Number of trainees & grades who were met:** | 14 ST 3/4 trainees were met in two groups<br>5 ST 7 trainees were seen separately<br>No ACCS trainees were available to be seen |

| **Purpose of visit :** |
|---|
| Cambridge University Hospitals NHS Foundation Trust was visited as part of the rolling review of training in Anaesthesia in all Trusts in the East of England.<br><br>The GMC trainee survey data for anaesthetic training at CUHFT, including individual comments relating to patient safety, was available for the visiting team, as was the trainee feedback collated through the ARCP process. The only red outlier for the 2012 and 2013 surveys was for clinical supervision, and the patient safety comments related to the fast track recovery and the workload for the second on call. The visiting team were also aware of the Trust response to these concerns. |

**Strengths:**

- All trainees interviewed commented on the diversity and complexity of the case mix they are exposed to and felt this to be extremely positive.
- In-theatre teaching is excellent and trainee supervision appears to be generally appropriate at both ST3/4 and 7 level
- Delivery of intermediate training modules is good, although sometimes time pressured
- Senior trainees are given appropriate clinical exposure and responsibility
- Generally consultant anaesthetists are supportive and there was no reported undermining
- Training in Obstetrics, Critical Care and Neuro anaesthesia was reported as excellent
- The majority commented that they would recommend their training and placement at Addenbrookes to others

**Areas for development:**

1. Induction: Although this appears comprehensive, some aspects of the Anaesthetic specific induction may be a little superficial and did not address practicalities such as working principles, the function of anaesthetic machines etc.
2. Formal Teaching: FRCA teaching is currently concentrated into the period immediately before examinations. While this may seem logical it does disadvantage individuals who may find attending impossible due to modular commitments. This teaching occurs out of the normal working day and the long shift patterns were noted. Trainees whose list overrun are also unable to attend.
3. Some consultants perhaps overestimate the abilities of trainees who have just completed Core Training. Some trainees felt overwhelmed for their first few weeks. Generally none stated that they were asked to work beyond their comfort zone and competence, but incidents were described where this was clearly not the case.
4. ST 7 trainees are not infrequently moved to support the service
5. Consultants are generally reactive to their out of hours duties and wait to be called by their on call trainees, rather than proactively reviewing the emergency workload requirements. Given the service pressures (described below) this needs addressing. The survey feedback relating to clinical supervision may, in part, reflect this.
6. It is not uncommon to split some of the key units into a 2 and 1 month block. While this may approximate to a pattern of spiral learning it is generally regarded as disruptive by the trainees
7. Day time trauma calls are taken by a designated consultant limiting trainee exposure
8. The access to IT facilities in the department is inadequate for such a large cohort of trainees.

**Significant concerns:**

Significant concerns with regard to training are closely related to service pressures.

1. Solo lists are an important part of training but trainees all felt isolated when undertaking them. It appears rare to be given a break and unusual for a senior doctor to contact them.
2. Lists frequently run over and it is the norm not to cancel cases. Solo trainees are expected to finish their lists. Emergencies are correspondingly delayed.
3. There is inadequate day time provision for surgical emergencies. Much work is thus pushed into the evenings and nights
4. The duties of the second on call are numerous. They consist of responsibility for overnight recovery (fast track), holding the Cardiac Arrest and Trauma bleep, covering 3 junior trainees across different specialty locations and the ICU trainee for airway issues, and a paediatric pain round has recently been added to weekend day time duties. This is frequently compounded by pressure from theatre admin to open a second emergency theatre. The overnight recovery has been a source of patient safety anxieties. It is clear that many of the patients in this area are level 2, that the recovery staff is not always trained to this level, and that significant input is required from the second on call. The proposed surgical cover for those patients not discharged does not seem to be working effectively. This feedback triangulates with that from the 2013 GMC trainee survey.
5. Handover appears to be all but non-existent. Trainee shifts run back to back and there is no senior level continuity
6. A large number of post CCT 'fellows' work in the department. These posts have a developmental focus for the individuals concerned and there is a potential clash with trainees for training opportunities.

**Requirements:**

**Many of these requirements have the potential to compromise patient safety as well as having training implications**

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.
2. A process should be put in place to ensure that all those working in isolation receive adequate breaks.
3. A review of emergency theatre provision is essential from both a service perspective but also in the context of the impact on training.
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.
5. A formal handover process must be put in place
6. Consultants must adopt a proactive approach to their on call duties and should physically ensure that there are no issues before going home
7. Paediatric pain rounds at weekends should be undertaken by the on call paediatric anaesthetist.

| **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.<br>2. A review of the formal teaching programme in encouraged, again in consultation with the trainees.<br>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.<br>4. It is not unreasonable in a major trauma centre for trainees to gain exposure to the acute management with the direct consultant supervision.<br>5. Minimise the splitting of time spent in key units |

| | | |
|---|---|---|
| **Timeframes:** | **Action Plan to Deanery by:** | Tuesday 6th May 2014 |
| | **Revisit:** | 12 – 18 months |

**Head of School: Dr Simon Fletcher** **Date: 5th March 2014**