Health Education East of England

School of Anaesthesia Visit to James Paget University Hospitals NHS Foundation Trust Executive Summary Date of visit: Monday 11th November 2013	
Deanery representatives:	Dr Simon Fletcher HOS, EOE Dr Helen Hobbiger RA, Anglia Dr Philip Hodgson, Quality Lead Dr Maria Ochoa-Ferraro, Trainee Representative
Trust representatives:	Dr Matthew Williams, Director of Medical Education Dr Pushpa Nathan, College Tutor Dr Edward Lams, Clinical Lead for Anaesthetics Dr Dhiraj Ail, Lead ICM Mrs Irene Walker, Postgraduate Medical Education Manager
Number of trainees & grades who were met:	3 ST trainees were interviewed 3 Core trainees were also interviewed, 1 Core trainee submitted a written report

Purpose of visit:

The James Paget University Hospital was visited as part of the rolling review of all Trusts in the East of England. It had received a number of red outliers in the GMC Trainee Survey so had been prioritised in this process.

Strengths:

All trainees were satisfied with the training they were receiving. The department is very friendly with a training culture and is providing structured and reasonably comprehensive coverage of the core syllabus.

Training opportunities at ST level are limited but there are more than enough opportunities to support a 1 year placement. Clinical responsibilities are appropriate for the level of training and experience with no examples of working beyond level of competence. Clinical support is excellent, day and night.

There has been no undermining or bullying.

Specifically;

- **Induction** lasted 3 days covering Trust (mainly mandatory training) and departmental issues.
- **Novice Trainees** are well supported both clinically and with a structured teaching programme. The current trainees passed their IAC at 3 months.
- **Core Training** is well structured, with a good pass record at primary FRCA.

- **ICU training** is delivered in a 3 month block but not always linked with on call in that area.
- **ACCS** trainees were happy with both EM and AM components, busy but with excellent experience and support. There are some issues around the structuring of the ICM/anaesthetic components. Tutor allocation is appropriate for ACCS stream.
- **E-portfolio** is in use with no obvious issues.
- **Teaching** is well supported within the department, particularly at primary level, and the post graduate facilities are excellent. Simulation forms an appropriate part of this training. Formal teaching for ST trainees is less developed but all reported no difficulties obtaining time to attend regional courses and meetings.
- There is adequate daily provision for emergency surgery with very little taking place after midnight. Working time directives are observed.

Areas for development:

1. **Induction Programme** at 3 days was regarded as lengthy but still did not allow completion of essentials such as personal log-on, in this paperless hospital.
2. **Novice trainees** are often exposed to 15 or more consultants which is not ideal during this part of training.
3. **Clinical experience**, particularly in obstetric anaesthesia, is limited. There is not a huge caseload and on-call in this area is often undertaken by ST trainees. The obstetric module is often timetabled during CT2 year leaving little time to achieve competencies within the placement
4. Like many hospitals of a similar size there is immense pressure on **trainee rotas**. Until recently there have been 2 tiers of on call (ICU/Theatres and Obstetrics). Theatre work has largely been covered by consultants giving trainees little exposure to anaesthetic emergencies. A number of fellows have recently been appointed to allow a 3rd tier of on call daytime weekends.
5. The ACCS trainee's block of anaesthetic training is split into two, with 2 x 3 month of anaesthetic training separated by 6 months of ICM. The E of E training committee mandates 6 month blocks.

Significant concerns:

The 3 'Red Flag' areas identified through GMC Surveys over the last few years (overall satisfaction, adequate experience and regional teaching) have been addressed above and were not significant concerns at this visit.

Requirements:

It is understood why the ACCS training has been structured as it is. However, the necessity for this is less evident given the appointment of fellows and thus the splitting of the anaesthetic component should be discontinued. It is perfectly reasonable for ACCS trainees undertaking their ICU component to be on-call after 1 month.

Recommendations:
1. Induction programme - the structure of this should be reviewed to allow the completion of obvious practical necessities **2.** The number of consultants that a novice is exposed to in their first 3 months should be reduced and the majority of time should ideally be with around half a dozen. **3.** The obstetric module should be undertaken much earlier in core training. This will allow trainees to undertake extra training and on–call in this area and therefore help to ensure they obtain the necessary competence and experience. **4.** We strongly recommend that the structure of on-call is revised. The appointment of fellows provided a clear opportunity. Dual cover of ICM and Emergency theatre should be phased out. All trainees should spend time in all areas out of hours and the fellows should not monopolise the cover in one area. **5.** It is further recommended that a Consultant only rota should operate for emergency surgery after 10pm. This would reflect the current situation with little emergency work taking place after this time. A trainee should cover emergencies until 10pm with appropriate consultant supervision. After 10 pm there should only be two tiers of trainee on call. It is understood that full implementation of these recommendations may not be possible immediately.

Timeframes:	**Action Plan to Deanery by:**	10th March 2014
	Revisit:	3 years

Head of School: Dr Simon Fletcher **Date: 10th December 2013**