Health Education East of England

School of Postgraduate Surgery Visit to East and North Hertfordshire NHS Trust Visit Report Friday 5th December 2014	
HEEoE representatives:	Dr Jonathan Waller - Deputy Postgraduate Dean - Quality Dr Rebecca Viney - Deputy Head of Education & Quality in Primary & Community Care Mr Neville Jamieson - Head of Postgraduate School of Surgery and Associate Dean Dr Jeremy Chase - Foundation Training Program Director, West Herts Miss Emma Gray - Programme Director, Core Surgical Regional Training Committee Mr Raymond Marlborough - Regional Coordinator, The Royal College of Surgeons of England Ms Susan Agger - Senior Quality Improvement Manager Professor Tim Allen-Mersh - Chair, Regional Specialty Training Committee in General Surgery Miss Alison Clough - Lay Representative
Trust representatives :	Mr Nick Carver - Chief Executive TBC Miss McCue - Medical Director TBC Dr Shahid Khan - Director of Medical Education Dr Deepak Jain - Foundation Training Programme Director Mr Tim Lane - Foundation Training Programme Director Mr Fred Schreuder - outgoing College Tutor for Surgery Dr Melanie Hodgson - GP Training Programme Director Dr Emma Salik - GP Training Programme Director Mrs Christine Crick - Medical Education Manager
Number of trainees & grades who were met:	The visitors met with 2 foundation, 2 GP, 8 core and 10 higher trainees across a range of surgical specialties and grades.

Purpose of visit :
In accordance with the review of the delivery of surgical training in all Trusts in the East of England, a visit was undertaken to East and North Hertfordshire NHS Trust on 5th December 2014. This was a joint visit to review the delivery of both core and higher surgical training in the surgical specialities within the Trust along with a review of foundation and GP training in Surgery in light of previous visits which had highlighted serious deficiencies in the delivery of surgical training, including inadequate supervision of F2 ENT trainees at night.

Strengths:
The F2 trainees no longer provide ENT cover at night There is a good case mix, supervision and access to WPBAs for the delivery of training to the higher General Surgery, ENT and Trauma & Orthopaedic trainees

Areas for Development:
The following areas were highlighted: 1. The core trainees were able to meet the needs of the clinical aspects of the surgical curriculum; however the SMART criteria are not explicit within the training programme. When constructing the rota consideration needs to be given to allowing for trainees to meet the SMART criteria. These are available from the JCST website http://www.jcst.org/quality-assurance/documents/qis/core-qis 2. As currently configured there is a single rota which includes the foundation, GP and core trainees. It was noted, however, that the goals and aims of core training are different to the old style "SHO". The development of a structured core training programme has required a more focussed approach to how training is delivered. 3. Accordingly a redistribution of the training roles of foundation, GP and core trainees needs to be undertaken, with the differentiation of core trainees. In particular the foundation trainees need higher levels of on-site supervision and the same level of responsibilities and competencies must not be expected of them by their clinical supervisors and nursing and other allied health professionals. It is suggested that, in order to do this, consideration is given to the introduction of a rota which doesn't include, for example, the Foundation Year 2 trainees in activities such as theatre which are a requirement for the core surgical trainees. 4. Despite identifying potential patient safety risks none of the trainees had used the Medical Director's hotline to report their concerns 5. The trauma & orthopaedic core trainees are concerned that they may be unable to gain adequate experience to be eligible to apply for an ST3 posts in trauma and orthopaedics because of a ruling that dynamic hip screws (DHS) must be done with a consultant present. This rule is obviously appropriate but arrangements should still be possible to allow the core trainees to be instructed on these cases. 6. Within Plastic Surgery it was noted that although there is extensive hand trauma experience (and a huge referral base for this service) there is limited training opportunities for the more junior trainees because the more complex cases are done by senior trainees and the consultant numbers are such that the consultants do not have sufficient time to take the junior trainees through these cases 7. Additionally in Plastic Surgery the Core trainees could find themselves carrying out unsupervised minor ops lists which could unexpectedly include more complex cases beyond their expected abilities and training. 8. With changes to the provision of service the Head and Neck experience in Plastics is lacking locally (Provided currently at Luton). It was noted that this may have implications for the level of trainee who can be placed at the Trust if this area of Plastic Surgery is their career goal and that such trainees would need to be placed in other regional units for such training. 9. There was variable consultant presence on ward rounds. In particular, for ENT there was a lack of consultant

presence and a different registrar lead each day which could cause confusion with patient management plan with changes in decisions being made.

10. The GP trainees did not have a named clinical supervisor

11. The quality of locum cover at weekends can be poor and the additional cover and support this was intended to provide at weekends could be inadequate leaving the problem of the trainees encountering difficulty with managing the workload and multiple referrals.

12. The delivery of induction for ENT and Plastic Surgery trainees was patchy. August induction was provided and was reported to be good however the trainees who rotated to the Departments in December did not receive an induction (at least in part because they could not be released from departmental duties to attend the induction which had been arranged). This caused additional problems with the cross cover arrangements between Plastic Surgery and ENT at junior levels where the appropriate skills might not be available to deal with referrals or inpatient issues.

Significant concerns:

1. The lack of an airway management escalation protocol.

2. Lack of airway management at induction for ENT and Plastic Surgery core trainees

3. Perception of insufficient support from ITU for ENT airways issues

4. Unsupervised core trainees operating in Plastic Surgery

5. Plastic Surgery trainees being detained in overbooked clinics when they were expected at emergency handover

6. The ENT/Plastic Surgery trainees do not feel safe when required to cross cover as they do not consider that their skill set is transferable

7. The combined ENT/Plastics rota requires the trainees to undertake 7 consecutive nights on-call which is unacceptable given the workload and inadequate subsequent rest period

Requirements:

1. The core trainees leading theatre lists without a nominated consultant identified must cease immediately. Access to trauma lists must be improved and when the lists occur there must be a dedicated consultant.

2. An airways management protocol must be provided within 1 week of receipt of this report.

3. ENT/Plastic Surgery cross cover must be addressed to ensure the trainees feel safe. In particular the issue of transferable skills, including trainee confidence in airway management must be attended to.

4. A comprehensive induction for ENT and Plastic Surgery trainees must be provided each time the trainees rotate not just for the August intake of trainees, and must occur before the first on call.

5. The provision of an appropriate link with ITU needs to be established

6. The arrangement of 7 nights on call for the ENT/Plastic Surgery rota needs to be addressed

7. The day surgery trauma lists must have dedicated time to allow trainees to benefit from the training opportunities available. The day surgery trauma lists should have patients booked in under a named consultant who would be the responsible consultant for that list.

Recommendations:
It is recommended that the Trust review reasons for the failure of their medical director hotline, and take appropriate remedial action.

Action Plan to Health Education East of England by:	
An airways management protocol to be sent to Mr Jamieson by 12 December 2014 An action plan to address the concerns surrounding ENT/Plastic Surgery within 1 month of receipt of the visit report An action plan to address the remaining issues within 3 months of receipt of the visit report	
Revisit:	A revisit with the GMC will be undertaken March 2015

Visit Lead: Mr Neville Jamieson **Date: 8 December 2014**