Health Education North Central and East London
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Developing people for health and healthcare

Pan-London Quality and Regulation Unit

Chelsea and Westminster Hospital NHS Foundation Trust

Core Surgical Training

Quality Visit Report

Date of visit: 19 May 2015

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Health Education
North West London

SPECIALTY-FOCUSED VISIT REPORT

Visit Details	
LEP	Chelsea and Westminster Hospital NHS Foundation Trust
Specialty	Core Surgical Training
Date of visit	19 May 2015
Background to visit	Core Surgical Training (CST) was last visited at Chelsea and Westminster Hospital NHS Foundation Trust in September 2013. The Trust had successfully closed all actions on the resultant action plan and their General Medical Council National Training Survey (GMC NTS) results had improved since 2013. The Head of the London Specialty School of Surgery wanted to assess the progress the Trust had made in core surgical training and whether this could be sustained in the future.
Visit summary and outcomes	The visit team initially met with the senior management and postgraduate teams, this was a joint meeting with all of the specialties being visited on the day. Following this the surgical visit team met with the clinical director and college tutors, and then the core surgical trainees across all specialties and had a short meeting with the non-training grade doctors. Finally, the visit team then met with the clinical and educational supervisors, before feeding back the findings to the senior management and board representatives. The visit team was pleased to see that there had been a significant improvement since the last visit in September 2013. During the visit the visit team were pleased to note the following examples of good practice: • The plastic surgery and orthopaedic rota at night had been significantly improved through the introduction of a hospital at night team and an emergency hand surgery list during the day. The visit team were pleased to see that the trainees were able to attend the emergency hand surgery list so that they could learn which referrals to this list were appropriate. • The consultant body were all very engaged in education and were very approachable, and the trainees were pleased with the educational experience they were receiving. • The visit team was impressed that the trauma meetings consistently had a strong consultant presence. • Core trainees (CT) in plastic surgery felt that they were getting a good balance of service and training and enjoyed having some ability to choose lists based on need.

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There were some concerns that were identified at the visit which are detailed below:

- There was an anxiety about the loss of foundation trainees in August 2015, and the fact that there was no departmental plan in place to cope with this.
- There was a need to tighten the Medirota in general surgery in order to ensure that the CT were better assigned to specific theatre lists and that they had a more structured timetable. This could also be organised so that the core trainees were paired with higher level trainees rather than a specialty trainee year three (ST3).
- The number of non-training grades could impede the experience of core trainees in trauma and orthopaedics.
- Trainees said that they were happy that consultants would complete their workplace-based assessments (WPBAs); however from analysis of Intercollegiate Surgical Curriculum Programme (ISCP) the levels of completed assessments for the core trainees in the department were low. There was a need to ensure the WPBAs were being completed.

The visit team was pleased to report that all core surgical trainees were present at the visit. The trainees all reported that they would recommend their current post to a friend. However concerns were raised regarding how the posts may be affected by the reduction in foundation doctors.

Visit team

Lead Visitor	Professor Nigel Standfield, Head of the London Specialty School of Surgery	**Lead Provider**	Mr John Brecknell, Deputy Head of the London Specialty School of Surgery
Lead Provider Representative	Miss Sophie Renton, Consultant Vascular Surgeon, Northwick Park Hospital	**External Clinician**	Mr Niall McGonigle, Lead Consultant Thoracic, Educational Supervisor, Royal Brompton & Harefield NHS Foundation Trust
Trainee Representative	Mr Peter Thompson, Barts Health NHS Trust	**Lay Member**	Ms Ann Rozier, Lay Representative
Visit Officer	Mr Rishi Athwal, Quality and Visits Officer		

Findings

GMC	Ref	Findings	Action and Evidence Required.	RAG rating of action

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Domain			Full details on Action Plan	
1	CS1.1	**Handover** Core trainees told the visit team that they had a morning handover at 8am. Trainees in orthopaedics said that there was always consultant presence in the morning handover, stating that there were usually four or five consultants there. Core trainees in plastic surgery said that their handover was less formal than the trauma and orthopaedic handover. They told the visit team that the handover was not consultant led, but there was a consultant presence. In general surgery core trainees said that a consultant would be present every morning and they would review all of the emergency patients. On a Saturday, trainees stated that the consultant would be present for handover. All trainees indicated that there was a consultant presence at the weekend but said that they may not review every patient. However in urology the trainees stated that all patients were reviewed by a consultant every day.		
2	CS2.1	**Clinical governance** Core urology and trauma and orthopaedic trainees told the visit team that there was a weekly morbidity and mortality (M&M) meeting for them to attend, and plastic surgery trainees said that they had one every three months. All trainees indicated that they would also receive feedback and had clinical governance days every few months. Clinical tutors told the visit team that the five steps to safer surgery had been adopted and was now the standard practice. Tutors also reported that they had recently spoken to core trainees regarding quality improvement projects, but felt that trainees were of the opinion that these were not a priority.		
5	CS5.1	**Workplace-based assessments (WPBAs)** Core trainees in plastic surgery informed the visit team that the consultants on the burns unit were generally available to complete their WPBAs.		

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		Orthopaedic trainees stated that they were allocated to a few consultants and attend their lists. Trainees reported that this resulted in them getting to know the consultants well, which in turn assisted in signing off WPBAs in a timely manner. Trainees in general surgery felt that despite the fact that consultants were approachable, it would be easier to get their WPBAs completed if they had an assigned mentor and a timetable with specified theatre lists. Core paediatric trainees reported that they had no issues getting their WPBAs signed off. One trainee stated that the majority of these were completed by the consultants whereas the other stated that they were mostly completed by the higher trainees. There was a consensus among the trainees that the consultants were approachable and that they would complete WPBAs for them should they ask. None of the trainees felt that they would struggle to meet their required WPBA numbers by the end of their placement. Despite the positive comments from the trainees regarding their ability to get their WPBAs completed, the visit team reviewed the numbers of assessments completed by the core trainees prior to the visit and found them to be low.	Educational supervisors to work towards the identification of trainees underperforming against WPBA requirements and trainers to continue to be accessible for the delivery of assessment in the workplace	**Green** Recommendation
6	CS6.1	**General surgery** The visit team heard from trainees in general surgery placements that there had been three new consultant appointments in the department. Trainees reported that there were a lot of theatre lists available, but said that due to the 'mega firm' organisation, it was difficult to find one mentor to guide them through their training. Trainees said they were spread thinly between lots of different teams, but said that there were a lot of learning opportunities. Educational and clinical supervisors stated that there were lots of training opportunities available to the trainees, but they said that they were not specifically timetabled to them. Consultants agreed that improvements needed to be made with the Medirota coordinator in order to allocate the trainees to more theatre.	There is a need to tighten the Medirota in general surgery in order ensure that the CTs are better assigned to specific theatre lists including day case lists in the treatment centre and that they have a more structured timetable. The rota co-ordinator should avoid allocating CTs to lists in which an ST3 trainee has also been allocated	**Amber** Mandatory Requirement
6	CS6.2	**Urology** The visit team was told by core urology trainees that they were enjoying their placement and		

		that it was very well set up for training. Trainees indicated that there were good opportunities for one-on-one supervision and said that they were able to get to five theatre sessions per week. Educational and clinical supervisors told the visit team that they felt the trainees enjoyed the job and that they felt it was a good core urology training post.		
6	CS6.3	**Plastic surgery** Core plastic surgery trainees told the visit team that they received a very good training experience and a gained exposure to a good variety of cases. Trainees reported that the opportunity to gain experience in the burns unit was excellent and that they were able to attend their burns management teaching sessions which they said were very good, and at the right level for a core trainee. Trainees said that the burns consultants were very good at being clinical and educational supervisors and that they were able to get to a theatre list every day. If a list was cancelled then it was possible for them to self-allocate to another one. The visit team heard from the trainees that there was no longer a specific carpal tunnel list stating that these cases were now spread across the other theatre lists. Trainees indicated that they had mixed exposure to these carpal tunnel cases. Non-training grades in plastic surgery said that there were a lot of vacancies on the rota, and therefore felt that their presence provided cover which enabled the trainees to gain more relevant experience. Educational and clinical supervisors felt all the core trainees were enjoying the plastic surgery job. They said that Local Faculty Groups (LFGs) had been running throughout the year. Supervisors reported that a hospital at night team had been introduced which had significantly reduced the workload for the core trainees at night, along with the introduction of the day hand clinics. Consultants stated that this was working very well, but they said that they were due to lose two Foundation Year 1 (F1) doctors from August 2015 and one F1 from the hospital at night team. It was felt that this would make it very difficult to maintain a rota. The clinical tutors reported that the recommendations received at the last visit in September 2013 had resulted in the hand unit moving to a much more consultant led service. They said that trainees were now present on the hand unit for training only, and wanted to make this	Ensure that core trainees are given good access to carpal tunnel cases as there are a lot done within the Trust and they should be done at core level.	**Amber** Mandatory Requirement

		the case for all elective work. Although the core trainees were still delivering the hand service overnight, there was a new book of guidance and improved access to senior support.		
6	CS6.4	**Trauma and orthopaedic surgery** The core trainee told the visit team that the experience and exposure received in their core trauma and orthopaedic placement was very good. However trainees did state that there was a lack of trauma experience, stating that there were not many chances to get fractured neck of femur (NOFs) experience. The trauma core trainee indicated that there were three non-training grade core training year 3 (CT3s) that had their own trauma lists which it was possible to attend if they were away. The trainee also stated that they would sometimes come in at the weekend in order to go to the trauma list as it was good experience. The non-training grades told the visit team that they felt they worked well with the core trainees. They said that their presence enabled the trainees to be released to attend training, and that the trainee was assigned to more lists. Educational and clinical supervisors told the visit team that the lack of trauma access for the core trainees is partly due to the fact that there was a lot of more complex trauma work in the department that was not suitable for core trainees.	Please review whether it is possible to rota the core trauma and orthopaedic trainee onto more trauma lists. Caution is needed to ensure that the CT3s are not taking training opportunities away from the CT1/2.	**Amber** Mandatory Requirement
6	CS6.5	**Theatre lists** The visit team heard from the trainees that they would usually be able to get to four theatre lists a week across the core surgical specialties. Trainees that had been working in general surgery stated that their rota was less structured. This meant that the trainees had to be flexible to ensure they could attend four theatre sessions a week. They said that they were not timetabled to go to certain lists but said that they could attend any available lists providing suitable cover for the emergency bleep was arranged. Trainees said that there was a mix of skill levels among the higher trainees that they were paired with on theatre lists. They said that they gained more from the experience when paired with a higher level trainee rather than a Specialty Training Year 3 (ST3) trainee. The core surgical trainees felt that it may be better for them to be paired with the higher level trainees but said that this was not currently possible due to the fact that there was a rolling	The rota should be organised so that the core trainees are paired with a higher level trainee rather than a Specialty Trainee Year Three (ST3) in order to maximise their learning experience.	**Amber** Mandatory Requirement

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		rota in place. The clinical tutors told the visit team that they were confident that the core trainees would be able to attend at least four theatre lists per week and two clinics. They said that the exposure they would get on those lists would depend upon the level of the higher trainee they were paired with. They said that there were not dedicated training lists for the core trainees, but that they had ensured that there was a good amount of training available on the existing lists. The visit team was told that there was a lot of day surgery taking place within the department and clinical tutors said that there was potential for the core trainees to attend these lists if appropriate. They said that there were a lot of lists available, should any trainee feel they were short of experience.		
6	CS6.6	**On call** **General surgery** The visit team was told that the core general surgery rota was a one in seven. Trainees stated that at nights the workload was quite heavy. They stated that there were zero days on Mondays and Tuesdays after a weekend on nights. **Orthopaedics/ plastic surgery** The visit team heard that there was a joint orthopaedics and plastic surgery night rota which covered burns and the hands unit. Trainees told the visit the team that the list was high intensity, but stated that there was a plastic and orthopaedic higher trainee present. Trainees said that they received referrals from a large catchment area and said that the decision on whether to bring the patient in was taken by them. However core trainees felt that they could call on the higher trainee for advice when needed. The visit team heard that since the last visit, where concerns were raised about this rota, a daily hand clinic had been introduced. Trainees stated that this had significantly reduced the on call workload. They said that as long as there were free slots in the next days hand clinic, it was possible to book patients into it rather than calling them in at night. Trainees told the visit team that they were also able to attend this clinic meaning it was possible to see the cases that were diverted to it. **Trauma and orthopaedics (T&O)** Core trainees in Trauma and Orthopaedics told the visit team that they would sometimes be		

		able to attend the T&O theatre list at the weekend dependant on how busy the shift was. Some trainees would occasionally come in at the weekend in their own time to attend this list as it is good experience.		
6	CS6.7	**Ward rounds** The visit team was told by the core trainees that the surgical ward rounds usually involved patients on five or six different wards. However trainees said that there was not a problem of losing patients. They said that they had a surgical admissions unit which was available between 8am and 5pm.		
6	CS6.8	**Bullying and undermining** The visit team was told by the core surgical trainees that they had not experienced any bullying or undermining behaviour. One trainee said that communication between teams was sometimes difficult, but did not feel that this amounted to bullying or undermining behaviour. Another trainee felt that compared to other trusts the communication between teams was in fact better at Chelsea and Westminster Hospital. The general surgery trainees said that they had a lot of communication with obstetrics and gynaecology and said that there were no issues with them; they said that most communication was at a core trainee to core trainee level. Finally trainees said that Mr Behar was very supportive and encouraged them to escalate any problems straight to him. Clinical tutors told the visit team that they felt Chelsea and Westminster Hospital was a very friendly hospital, and said they would be surprised if their trainees were experiencing and bullying or undermining behaviour.		
7	CS7.1	**Loss of foundation doctors** Core trainees expressed concerns to the visit team regarding the fact that they had not been informed of how the department planned to cope with the loss of foundation trainees from August 2015. They said that they were concerned at the possibility of being called to the wards to provide cover, and that all trainees would be moved onto one large rota. The core trainees felt that the workload was such that the implementation of a 'mega rota' would not be possible. Clinical tutors told the visit team that there was not a finalised a plan in place for the	The Trust must inform the visit team of their plans with regards to the loss of foundation trainees' in surgery. The School of Surgery would expect the trust to replace the F1s one for one.	**Amber** Mandatory Requirement

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		reduction of foundation trainees from August 2015. Clinical tutors said they would need to ensure that there were enough trainees for the junior rota as they were losing the Foundation Year 1 doctors (F1s). The visit team were told about some ideas currently being discussed which included using research trainees to fill the night rota, applying for physicians associates and having drugs charts written up by the pharmacists and checked by the anaesthetists.			

Good Practice	**Contact**	**Brief for Sharing**	**Date**

Other Actions (including actions to be taken by Health Education North West London)

Requirement	**Responsibility**

Information and reports provided to the team prior to the visit

DME Annual Report	*No*	Regulator Reports/Data	*No*	LFG Reports	*No*	MEM minutes	*No*
GMC Survey - trainees	*Yes*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*Yes*		
PVQs - trainees	*No*	PVQs - trainers	*No*	Result of school survey	*No*		

Signed

By the Lead Visitor on behalf of the Visiting Team:	*Professor Nigel Standfield*
Date:	*08 July 2015*