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Quality and Regulation Team (London and South East)

Guy's and St Thomas' NHS Foundation Trust
Foundation Training
Specialty Focused Visit

Quality Visit Report
19 January 2016
Final Report

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Visit Details	
Trust	Guy's and St Thomas' NHS Foundation Trust
Date of visit	19 January 2016
Background to visit	The last Trust-wide Review to Guy's and St Thomas' NHS Foundation Trust took place in May 2012. Foundation (surgery) training was last visited in January 2015 as there had been on-going concerns about the trainees' educational experience. There had also been a reconfiguration of foundation surgical posts in August 2015. The visit was carried out to ascertain the impact of these changes on training in the department.
Visit summary and outcomes	The visit team met with the director of medical education, foundation training programme directors, 22 foundation doctors in training from POPS (proactive care of older people undergoing surgery), general surgery (upper and lower gastro-intestinal and emergency general surgery), head and neck, trauma and orthopaedics and urology, as well as a number of foundation clinical and educational supervisors. In general the visit team found the following areas of good practice: • The POPS, urology and vascular trainees felt very well supported by their consultants. • Trainees commended the nursing staff at the Trust and praised the support they provided. • The POPS trainees reported that they were asked for and were able to provide feedback on their training experience. • No issues were reported with cytotoxic prescribing, site marking and taking consent. • In vascular, head and neck and urology all the trainees had good exposure to training opportunities. • There were good teaching opportunities in vascular and POPS. However, the visit team also noted the following areas which required improvement: • In gastro-intestinal (GI) surgery the administrative workload was very heavy and the opportunities for training were limited and of little educational value. The on call was under-staffed. Formal clinical supervision in general surgery was sub-optimal particularly as the trainees had little contact with their named clinical supervisor in day to day practice. • Departmental induction was found to be variable. The departmental induction to POPS, orthopaedics and urology was reported to be satisfactory, but unsatisfactory in general surgery and non-existent in head and neck. Trainees rostered to be on call or off duty on their first day in post missed induction. • Inappropriate duties: there was one ward without phlebotomists. • Clinical supervision: this was broadly satisfactory, although doctors in GI felt stretched out of hours. Some trainees did not know who their named clinical supervisor as they did not either work or interact with them. Their review forms were often signed off remotely without any face to face discussion. • Hours: Most foundation doctors apart from those in the POPS posts felt that they worked beyond their rostered hours, often by two to three hours daily. • Handover: There was no formal handover of patients to the on call team or after on call on week days. No patient safety issues had occurred as a

	result but this was largely felt to be due to the excellent nursing staff. • Feedback: Most of the trainees were unaware of their existence of foundation trainee representatives (officially 14 appointed) through whom they could raise feedback about their training to the local faculty group.. • Practical experience: The POPS posts were reported to be generally very good. The F1 doctors would generally recommend these posts, but the F2 doctors, felt that they were insufficiently stretched, and at times felt over-supervised and largely supernumerary. The visit team felt that the Trust should look at opportunities to balance the workload between the POPS F2 doctors and the busy surgical specialties. • Teaching: The emergency general surgery trainees found it difficult to attend teaching sessions due to their workload, and overall attendance was falling well below the required 70%. Of the 22 doctors interviewed (15 F1s and 7 F2s), 13 reported that they would recommend their jobs. Of the remaining 9, 5 were in GI surgery posts.

Visit team			
Lead Visitor	Dr Jan Welch, Director of South Thames Foundation School	**Trust Liaison Dean**	Dr Anand Mehta, Trust Liaison Dean, Health Education South West London
External Consultant	Dr Kilian Hynes, Foundation Training Programme Director, Royal Free London NHS Foundation Trust	**Lay Representative**	Catherine Walker, Lay Representative
Scribe	Jane MacPherson, Deputy Quality and Visits Manager	**Observer**	Nimo Jama, Quality Support Officer

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement / Recommendation
	Educational overview and progress since last visit The lead foundation training programme director (FTPD) gave a presentation to the visit team which outlined work carried out since the previous visit, both to improve training and implement Broadening the Foundation Programme. The surgical posts had been reconfigured, including the move of some posts to the POPS model of care. The FTPD summarised the new arrangements, comprising the following foundation year one (F1) and foundation year two (F2) posts: **Surgery** F1 – Gastro-intestinal (GI) surgery – 10 F1 – Vascular – 5		

F2 – Trauma and orthopaedic surgery (T&O) – 4

F2 – Urology – 3

F2 – Otolaryngology (ENT) – 3

POPS (Proactive Care of Older People undergoing Surgery)

F1 – Orthopaedics – 4

F1 – Urology – 2

F2 – Vascular – 2

F2 – Urology – 2

The lead FTPD also provided an update on the action plan issued after the previous visit:

Update from last action plan

- Issues with prescribing cytotoxic drugs: no issues were highlighted in the foundation survey; regular emails were sent out to staff members; a revised educational programme had been launched
- Site marking: also found to be no longer an issue in foundation survey; this was reinforced at induction; supervisors had been reminded
- F1 North Wing cover at night: increased support was being provided; a second higher trainee was on duty at night to support ward trainees; Trust was discussing task management system
- Urology theatre attendance: a log book had been implemented; trainees were encouraged to attend; feedback from August 2015 to December 2015 was good, whereas feedback from December 2015 to date was less than satisfactory (largely due to workforce shortage)
- Workload and hours: this was still reported to be an issue; the lead FTPD regularly met with the foundation trainees to monitor
- Careers guidance: F1 and F2 careers workshops had been introduced
- Local induction: a new local induction checklist had been introduced; Dr Toolbox usage had been increased; local induction compliance monitoring was taking place; medical education department was considering Trust-wide improvements
- Dr Toolbox: trainee reps had been allocated in specialties; F1s were finding this toolbox more valuable than F2s as they were mainly on the ward; the department was trying to

	encourage F2s to use it more • Attendance at weekly teaching: F1s tended to attend more in their first placement than in their second • Porters: portering team was engaged with the issues raised during the last visit; trainees had been reminded that they should not porter and should report any issues to the head of portering • Phlebotomy: a reinforced communication sheet had been introduced in clinical areas; the phlebotomy team was engaged and was actively looking at problem areas The FTPD informed the visit team that he had met with various trainees and had discussed any issues and implemented the following changes as a result: **Urology** • Changes to workforce structure • Consultant of the week system • Theatre/clinic log • Regular teaching • Appropriate tasks for F2s **GI surgery** • Regular teaching • New model of emergency general surgery care – appreciated by trainees • Supervision and support from higher trainee, consultant and nursing staff • Theatre / clinic time – variable • Workload issue **Vascular** • Workload issue but educationally valuable • Well supported by consultants, higher trainees and nursing team • Regular theatre attendance • Regular teaching • Now 24 hour junior clinical fellow support		

	ENT • Three F2s rather than two F1s • Issue regarding task appropriateness taken on board by department – the trainees complained that their jobs sometimes felt more suited to F1 • Regular teaching • Good support / supervision • Induction could be improved		
GMC Theme 1) Learning environment and culture			
1.1	**Appropriate level of clinical supervision** The trainees in the POPS, orthopaedics, head and neck and urology posts reported that they were well supervised. The trainees in general surgery reported that there was insufficient senior cover on duty at the weekend, particularly because the higher trainees were often in theatre, and therefore the foundation trainees felt very unsupported for several hours at a time.	Foundation trainees to be assigned a timetable covering their shift, which outlines who is responsible for their clinical supervision at all times, and the contact number for each.	Mandatory Requirement
1.2	**Taking consent** No issues were reported in this area.		
1.3	**Rotas and workload** In the first session of the day with the senior management team, the visit team heard that the hospital at night rota was being re-organised. An additional senior nurse practitioner had already been introduced but there were also plans to include an additional medical higher trainee on the rota at Guy's Hospital from April 2016 who would be able to provide support to the F2 doctors. The senior management team also reported that at St Thomas' Hospital, there was now a second medical higher trainee on at night to bolster support. The director of medical education (DME) also reported that the Trust had recruited five physician associates (PAs) to support the Trust's workforce. These were reported to be high quality staff and regular meetings were held with them to review their learning needs, support and resources. PAs had been introduced to acute medicine, orthopaedics and intensive care, but some departments, such as urology, were less comfortable with this concept, preferring to try and recruit nurse practitioners instead. These had been more difficult to appoint. The DME stated that the Trust was concerned about the foundation trainees' workload and was keen to showcase where the PA model worked, in the hope that other departments would choose to support their workforce similarly.		

	The visit team was also informed that POPS foundation doctors were being introduced who would look after the long term care of patients attending the Trust for acute surgery. There were concerns from most of the trainees (apart from those in POPS) that their rotas were not European Working Time Directive (EWTD) compliant. Many trainees, particularly those in vascular and GI, worked over their rostered hours daily. The general surgery trainees suggested that only having one higher trainee on duty at night was insufficient for the numbers of patients admitted. The visit team heard that the F1 trainee was responsible for ensuring that different patients were allocated to different teams, but the trainees commented that it was easy to make mistakes. The GI trainees reported that they found the weekends unmanageable and at times unsafe, although they commended the excellent nursing staff for their work in ensuring any mistakes were rectified and that patients were reviewed by a doctor in a timely fashion.	The Trust to look at opportunities to balance the workload between the POPS foundation year two trainees and the busy surgical specialties. The Trust to diary card foundation doctors. Foundation trainee reps to encourage and remind colleagues to participate in diary carding.	Recommendation Mandatory Requirement
1.4	**Induction** Departmental induction was found to be variable. The departmental induction to POPS, orthopaedics and urology was reported to be satisfactory, but unsatisfactory in general surgery and non-existent in head and neck. Trainees rostered to be on call or off duty on their first day in post missed induction. The POPS trainees reported that they received a comprehensive handbook and a timetable.	Departmental induction must be provided for any foundation trainee starting any post at any time of year, including those starting out of hours. The departmental inductions developed must be sustainable, of high quality and must include: • orientation and introductions • details of rotas and working pattern • clinical protocols	Mandatory Requirement
1.5	**Handover** The GI (both lower and higher) trainees reported that handover was only conducted verbally and was informal. Those starting in the day relied on the person on call to contact them by phone or by text to hand over any patients but there was no formal handover from the night team. An electronic patient record system had been set up to try and ensure that there was a layer of safety. The F1 trainees felt it was impossible to hand over all the patients on each ward in the morning following a night on call, due to the numbers of patients involved. The GI trainees reported however that every patient on lower GI was seen by them on the ward round on a daily basis and would therefore pick up any issues that had occurred overnight.	Trust to introduce a formal handover process for general surgery. Trust to create standard operating procedures for handover sessions. Trust to implement set times for handover. Trust to ensure appropriate attendance at departmental and inter-departmental handovers.	Mandatory Requirement
1.6	**Work undertaken should provide learning opportunities, feedback on performance, and**		

	appropriate breadth of clinical experience The head and neck F2 trainees felt that their job was more suited to an F1 trainee. However, they had the opportunity to go to theatre, which they found useful. Some F2 POPS trainees reported that they felt like a medical student at some clinics as at times they were not expected and therefore just had to sit and watch. The trainees confirmed that there was no longer any major issue with portering. The trainees reported that there was no phlebotomy service on one of the wards.	Trust to ensure that all wards have a phlebotomist.	Mandatory Requirement
1.7	**Protected time for learning and organised educational sessions** The visit team heard that upper and lower GI teaching had been introduced on a Friday, which the trainees were able to attend. The vascular and POPS trainees also confirmed that they had weekly teaching. The trainees occupying the emergency general surgery posts reported that they were unable to attend teaching sessions due to their heavy workload and either being 'on call' or having compensatory time off. The lead FTPD reported that the Trust had been trying to make changes to the foundation teaching programme as a result of trainee feedback, but he also suggested that the trainees had to be proactive about attending teaching sessions. He agreed that the trainers also needed to enable them to attend teaching sessions.	Trust to conduct an audit on the number of sessions that foundation trainees do not attend and the reasons given. Trust to send email to all foundation trainees and supervisors reminding them of the importance of attending teaching and that those with less than 70% attendance will not be signed off. Teaching sessions must be bleep-free and there must be protected time for departmental teaching for all foundation trainees. The Trust must communicate to foundation trainees which training sessions are mandatory and to senior doctors that foundation trainees may be absent from or late to the ward during teaching periods. **General Surgery** must ensure that there is appropriate cover on the ward so that the foundation trainees can attend teaching sessions.	Mandatory Requirement
GMC Theme 2) Educational governance and leadership			
2.1	**Organisation to ensure access to a named clinical supervisor** Some trainees did not know who their named clinical supervisor was or had no interaction with them. At times their forms were signed off remotely without any discussion with the trainees. The GI trainees were only informed of their clinical supervisor weeks after starting in post and were often allocated to a clinical supervisor who was never scheduled to work with them. The vascular trainees confirmed that they met with their clinical supervisor on a weekly basis.	Trainees to be an allocated a clinical supervisor who will have the opportunity to work closely with them and monitor their progress.	Mandatory Requirement
2.2	**Organisation to ensure access to a named educational supervisor**		

	All the trainees confirmed that they had an assigned educational supervisor.		
2.3	**Systems and processes to identify, support and manage learners when there are concerns** The visit team was informed that all trainees should be well aware of how to contact the postgraduate medical education team for support, if required. The clinical leads informed the visit team that 14 foundation trainee representatives had been nominated and that each was responsible for collecting feedback from a specific group of trainees. This feedback was discussed during the local faculty group meetings. The lead FTPD also reported that the FTPDs met with their trainees regularly. The POPS trainees all confirmed that they were regularly asked for feedback on their training experience. Most of the other trainees, however, were unaware of the existence of foundation trainee representatives via whom they could raise feedback about their training to the local faculty group. The three trainee representatives interviewed stated that not all trainees were allocated to a representative in their specialty, which meant that it was more difficult to give and collect feedback. The trainee representatives confirmed, however, that they had emailed their colleagues to ask if there were any issues with their training. They felt that they had not been in post long enough for any positive action to have occurred.	The Trust to ensure that the allocation of trainees to foundation trainee representatives is appropriate, so that all foundation doctors have an opportunity to raise any issues with their training. The Trust to ensure that all foundation trainees are made aware of who their foundation trainee representative is and what their roles and responsibilities are.	Mandatory Requirement
GMC Theme 3) Supporting learners			
3.1	**Behaviour that undermines professional confidence, performance or self-esteem** None of the trainees raised any serious issues regarding bullying and undermining. The visit team heard, however, that many staff members in lower GI were extremely stretched and stressed, and as a result remaining positive and optimistic in the face of such adversity was often difficult. The vascular trainees reported that, although workload was heavy, morale across the whole team was high. The F2 POPS trainees reported that they often felt somewhat over-supervised, as they did not feel that they had the opportunity to progress. The F2 trainees, many of whom had previously been in busy emergency department posts, felt that they had very little responsibility in their current post (in comparison to their previous post) and this led to them feeling at times demoralised. The F1 POPS trainees on the other hand reported no such issues, and felt that they had access to good training opportunities.	See Ref 1.3.	
GMC Theme 5) Developing and implementing curricula and assessments			

5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team was informed by the clinical leads that the Trust had reviewed the way POPS was interacting with the surgical teams to ensure that appropriate educational and training opportunities were provided to the trainees. Six F1s and four F2s had been moved into POPS surgery for a period of four months each. The trainees spent the first two months on the ward where they took part in joint ward rounds with physicians and surgeons. They then moved onto the next block which consisted of a month participating in nurse-led pre-operative assessment clinics where they saw complex older people with multiple co-morbidities. They also had the chance to make decisions and work with surgical teams in theatre. In addition, they spent some time in the community, where they visited rehabilitation units or other intermediary care centres. During the final block, they had two weeks of annual leave and two weeks of on calls. The visit team was informed that there was a formal educational programme for POPS trainees, with Friday afternoon teaching at alternate sites and the opportunity to learn about peri-operative surgery. The clinical leads reported that feedback on the training provided was collected at the weekly teaching sessions and was acted upon, as appropriate. The visit team heard that a formal evaluation of the POPS training programme was underway. The visit team heard from the urology trainer that when the department was fully staffed, the trainees were satisfied with their training experience. They stated that the department had lost five foundation trainees and that this had had a hugely negative impact on the team. The department was trying to address this issue by trying (often unsuccessfully) to recruit advanced nurse practitioners (ANP). The visit team was informed however that a new ANP was due to start in March 2016. The department was also looking at the possibility of using prescribing pharmacists to support the workforce. In ENT, the visit team heard from the foundation trainer that previously the department had two F1 trainees, but at the time of the visit there were three F2s in post, and it had taken the department a while to understand the new trainees' expectations for training. The visit team heard that the programme had been changed completely to enable the trainees to spend some time in the community and to ensure that the F2 trainees had access to some formal tracheostomy training. In general surgery, the visit team heard from the foundation trainers that Trust-grade doctors (at core level) had been recruited to try and alleviate the foundation trainees' workload. The visit team also heard that additional nursing support had been recruited in lower GI. In vascular, the visit team heard from the foundation trainers that six new core-level posts had		

	been introduced, in addition to two from cardiac, in order to try and maintain the changes made over the previous few years and to support the F1s and higher trainees. The trainers were aware that at times trainees had to stay later than their rostered hours but felt that this was mainly on the day when they were covering the big vascular ward round. The visit team was informed that a diary card exercise was due to be conducted.		
5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The GI trainees reported that they had little opportunity to attend clinics or theatre sessions and commented that it would be useful for them to have these sessions timetabled so that they could attend. The GI trainees felt that they spent most of their working day behind a computer undertaking administrative work. They did not find this work particularly valuable. The vascular trainees confirmed that they were able to attend theatre sessions. The urology trainees reported that they were timetabled to attend theatre and were encouraged to go, but in reality this was not feasible due to their heavy workload. The head and neck trainees reported that, although not timetabled, they were able to attend theatre sessions by mutually dividing the work between themselves.	Trust to undertake audit of opportunities the trainees have to perform practical procedures. Trust to consider and implement measures to augment the experience offered by the current post, and submit report detailing what has been done and provide evidence that the issues have been rectified.	Mandatory Requirements

Good Practice	Contact	Brief for Sharing	Date

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Jan Welch*
Date:	*18 February 2016*