Health Education England

Developing people for health and healthcare

Quality and Regulation Team (London and South East)

Croydon Health Services NHS Trust
General Practice
Specialty Focused Visit

Quality Visit Report

27 January 2016

Final Report

THE NHS CONSTITUTION
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Visit Details	
Trust	Croydon University Health Services NHS Trust
Date of visit	27 January 2016
Background to visit	The General Practice (GP) training programme within Croydon University Health Services NHS Trust has had significant, intransigent issues regarding training and education across different specialties. This had been evidenced by the Trust's action plan, which had five items for GP that had been open since 2012. The General Medical Council National Training Survey (GMC NTS) for 2015 showed several red outliers in GP programmes, mainly relating to workload, lack of time in clinics, lack of local teaching and adequate training experience. Particular concerns were around the GP posts in trauma and orthopaedics (T&O) and urology. The results for T&O indicated a lack of structure and awareness of GP trainees' training needs, which, as a result led to poor training experience and a lack of senior supervision and support. Concerns in urology were due to a lack of consultants and the department's ability to provide senior support. The Trust was also at 77 per cent compliance rate for the GMC Trainer Census, which was below the expected threshold. The visit team for GP, in conjunction with the visit teams for the Trust Wide Review and the Specialty Focused Visit for Foundation, needed to investigate the appraisal process for educational supervisors and how educational and clinical supervisors were being supported by the Trust. The introduction of the GP Charter in January 2016 outlined the education and training requirements for GP posts. The visit team was interested to see the extent of the dissemination and reaction to the GP Charter. In addition to the new GP Charter, the rotations for GP trainees will be changing to four-month rotations, instead of six-month rotations, in August 2017. The visit team wanted to gauge how the Trust would accommodate this and if there would be any perceived difficulties. The Trust historically had a high workload in all departments and the GP visit team was interested to see how the reduction of foundation training posts in surgery and medicine, as part of the Broadening the Foundation programme had affected the workload and role of GP trainees in the secondary care setting.
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit and for the well-attended sessions. The visit team met with the senior management team, followed by a meeting with the programme directors. There were two trainee sessions; the first with specialty training grades one (ST1) and specialty training grade two (ST2) GP trainees. These trainees were in Trust posts in the following specialties: trauma and orthopaedic surgery (T&O), obstetrics and gynaecology (O&G), paediatrics, care of the elderly, genito-urinary medicine (GUM), urology, psychiatry and emergency medicine. The second trainee session consisted of specialty training grade three (ST3) trainees training within GP practices within the Croydon scheme. The visit team also met with clinical supervisors from O&G, GUM, T&O, emergency medicine, paediatrics, dermatology, care of the elderly and urology. The final session of the day consisted of meeting the educational supervisors for the trainees in the Trust posts, who were GPs in practices across the Croydon scheme. The visit team was pleased to see that the programme directors were responsive and proactive to training issues in the Trust and that the trainees felt they were approachable and supportive. The programme directors could be more effective if channels of strategic communication were created. The Trust should look to implement this, especially in light of the changes in rotation length in 2017 and the implementation of the GP charter. In addition, the visit team suggested that more specialty clinical supervisors should engage with the Trust GP faculty meetings. The Trust should also look to engage the GP trainees more in local faculty groups (LFG) and the junior doctors' forum. The care of the elderly department must be commended for its use of a trainee representative to engage the GP trainees in the care of the elderly departmental meetings. The visit team found that most of the GP posts provided good support and supervision but there were concerns surrounding the merit of the urology post for

	GP training. A substantial majority of trainees the visit team met would recommend Croydon University Hospital for training. The visit team commended the T&O department, which had made substantial progress in developing the learning opportunities for GP trainees and was confident that this could be a sustainable positive change. The visit team was concerned to hear that in many specialties the lack of staff and the inability of the Trust to hire locums meant that the GP trainees' training and education was being impeded. GP trainees in care of the elderly and O&G, especially, reported very high workloads with little opportunity to attend clinics or teaching, in spite of the efforts of the consultants to timetable this. The gaps in the rota were also putting a significant strain on the existing staff, and trainees were concerned that if not adequately addressed, there was the potential for patient safety to be compromised. Trainees' ability to attend weekly GP teaching was variable, and was significantly influenced by the vacancy rates on the rotas. This was also the case for local teaching, which in some departments was not felt to be relevant to GP training, and catered more for specialty trainees within the department. Overall, the visit team found a Trust that supported the GP Trust posts and with the implementation of the GP Charter, the visit team felt confident that the GP posts would remain a relevant and valued source of education and training for GP trainees within the secondary care setting. This could be enhanced by increased strategic communication between the programme directors and the Trust's board.

Visit team			
Lead Visitor	Dr Rebecca Torry, Associate Director GP Specialty Training, Health Education South London	**External Representative**	Dr Veni Pswarayi, GP Associate Director, Health Education South London
Trust Liaison Dean	Dr Helen Massil, Trust Liaison Dean, Health Education South London	**External Representative**	Dr Kaushal Kansagra, Bromley Programme Director
Lay Member	Kate Rivett, Lay Representative	**Trainee Representative**	Dr John Crawshaw, Trainee Representative
Visit Officer	Lizzie Cannon, Learning Environment Quality Coordinator	**Observer**	Nimo Jama, Quality Support Officer

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			
GP1.1	**Patient safety** The visit team found that there was a lack of clarity regarding the process of how patients were referred from the local GP practices to the Trust. GP trainees stated that if a referral was not arranged, or the letter was not directly addressed to a specific specialty doctor, then the patient would be seen in the emergency department and be treated as a new case, not a referral. The trainees stated that for obstetric and gynaecological (O&G) and paediatric cases this could delay	The Trust is required to ensure that GP practices and Trust staff, including trainees are aware of the referral pathway for all patients referred from the GP practices to the Trust.	Mandatory Requirement

	patient care, which would better have been delivered by the relevant department from the outset. It was reported that at times there was a perceived lack of speciality support from the speciality teams for foundation year two and GP ST emergency department trainees. At times there could be a lack of expertise within the emergency department to deal with paediatric cases, depending on the experience of the higher grade emergency department trainees. The trainees were advised to seek help from the paediatric higher-grade doctor or trainee. The latter, who had a very high workload, were not always able to see the paediatric cases directly and might could only give advice. The GP trainees stated that this combined with the relative inexperience of some of the trainees in the emergency department and the high workload meant that trainees in emergency medicine were not always getting adequate support. There was a clear pathway for a very sick child. It was intermediate cases, which were problematic. The GP trainees stated that this was sometimes true of O&G cases too. Trainees were concerned there was a potential for patient safety to be compromised. The visit team heard from both paediatric and emergency medicine consultants that there was a good working relationship between the two departments and the paediatric staff were always encouraged to be supportive. The consultants had no concerns regarding patient safety. The visit team also heard that there would be a fully operational paediatric assessment unit by April 2016 which would give additional support to both paediatric and emergency medicine departments. The visit team heard that there were concerns regarding the continuity of care of gynaecology patients because of the gaps in the rota. There were different higher-grade doctors or trainees allocated to the gynaecology ward for the mornings and the afternoons. If these doctors were in theatre the care was covered by foundation or ST1 or ST2 trainees. The trainees stated that with the arrangement of lack of staff and covering multiple areas, including the emergency department meant there was the potential for breaches in patient safety. However, at the time of the visit no patient safety incidents had occurred.	The Trust is required to clearly outline the protocol for advice and referrals between the emergency department and other departments. This should be disseminated to all staff, including GP trainees.	Mandatory Requirement
GP1.2	**Serious incidents and professional duty of candour** The visit team heard of positive experiences from trainees who had reported serious incidents and had been fully supported through the process. This included support from management consultants and a detailed debrief at the end. Trainees did however state that it was not always clear who to send the Datix form and when trainees submitted forms there rarely feedback given.		
GP1.3	**Appropriate level of clinical supervision** The programme director stated that they had concerns regarding the clinical supervision levels in urology. This was due to there being one clinical supervisor for GP trainees in urology who could not always be present. In addition, gaps in the middle-grade urology rota produced an unstable environment for GP training. Consultant cover arrangements lacked continuity, which was detrimental to GP trainee teaching and learning in the department. The urology consultant stated		

	that trainees would always be able to access support but this could be via phone. GP trainees in the emergency department stated that the consultants were approachable and supportive. The GP trainees in care of the elderly and all other specialties GP trainees worked within reiterated this.		
GP1.4	**Rotas and workload** The senior management team and the programme directors acknowledged that the workload at the Trust was exceptionally high. The programme directors stated that it in part depended on the individual trainee but generally, trainees would frequently work over the rostered hours. The visit team also heard from the programme directors that the high workload was exacerbated by the lack of foundation doctors on some of the medical wards, and the difficulty in acquiring locum doctors. The trainees in care of the elderly described workload issues due to the lack of foundation doctors allocated to some areas of the wards. GP trainees stated that much of the ward work was more suited to a foundation trainee and was not always relevant to GP trainees. The visit team also heard that because of a lack of phlebotomists the GP trainees commonly took bloods. The visit team heard the rota for O&G had worked well, if fully staffed. The rota being a rolling ten week rota with ten doctors (who could be foundation year two, ST1 or ST2 trainees) allocated to each week. However, training posts had not been filled and the Trust had not been able to fill these gaps with locums. The trainees reported having to cover on calls, which had resulted in missing clinics which would have been excellent training opportunities. The consultants in O&G stated that the rota was short and this had limited trainees' learning opportunities but that by February 2016 the rota would be fully staffed as a new rotation of trainees came into the department. The GP trainees in paediatrics stated that the rota was adequate but that because of the way the rota was structured if trainees wanted to take annual leave there was a restriction on which weeks could be taken, unless trainees were willing to miss clinics, as possible weeks for leave included those when they were allocated to attend clinics. The visit team heard that the T&O department was also short-staffed which inhibited trainees from attending clinics and lists. The rota was precarious because it had two gaps, which when combined with trainees taking leave for study, rest or sickness meant the workload on the trainees left ensured that no learning opportunities could be accessed. The visit team also heard that when locums were hired it did not always ameliorate the workload because the locums were sometimes unclear of the department's ways of working. The consultants stated that the rota change in 2017 which would shorten GP trainee rotations to four months, instead for six months, would allow for a larger exposure in different settings, but that trainees might be less able to optimise the learning opportunities available with two months less.	The Trust is required to ensure that the educational integrity of the GP posts is maintained, despite rotas being short staffed. Trainees must be able to attend local teaching, clinics and the weekly GP teaching, set out under the GP charter.	Mandatory Requirement
GP1.5	**Handover**		

	The visit team heard that the handover in the emergency department was generally quite informal because of the shift patterns in the emergency department. However, it was felt that these were adequate and involved the right people. In addition, the trainees stated that when the emergency department was very busy the handover was more structured with formal board rounds, where all patients were discussed.		
GP1.6	**Protected time for learning and organised educational sessions** The programme directors were aware that the workload was high and that trainees, although encouraged to attend teaching by consultants, were deterred. The programme directors stated that at times trainees decided to forego teaching because trainees would then have to stay later to cover the work that had built up during teaching. However, the programme directors stated that the attendance at GP training on Wednesday afternoons had recently been very good, taking in to account nights and leave, with approximately half of trainees attending. The visit team heard from the GP trainees in care of the elderly that it varied on which ward and which consultants were working whether trainees would be released for weekly teaching or to attend clinics. Trainees also stated that it depended on how much support there was to cover the trainees' workload while away on teaching. The trainees stated that this was partly determined by whether there were foundation trainees allocated to the workload. The senior management team stated that there was a 'Whatsapp' group that promoted an equitable distribution of doctors across the Trust, with trainees moving from different departments depending on workload. However, the GP trainees stated that this was only for foundation doctors and this did not necessarily work effectively on the care of the elderly wards. The visit team heard that GP trainees in O&G were not released for any the weekly GP teaching. However, the consultants in O&G stated that they were usually released to attend the weekly GP teaching, but conceded that this was made difficult when the rota was short. The consultants stated that this was made up by the protected teaching time on Thursdays and Fridays. The programme directors stated that local teaching for GP trainees in paediatrics was good when based on the latest internal trainee feedback from November 2015. The visit team heard that the local teaching in paediatrics was good, if not always relevant to GP trainees, but trainees were not regularly released for weekly GP teaching. GP trainees in GUM were not released for weekly GP teaching. The consultants corroborated this, stating an historical precedent that the GP posts were established with the agreement that trainees would not been released for teaching on Wednesday afternoons. However, with the introduction of the GP Charter, GP trainees will need to be released for weekly teaching on Wednesdays.		
GMC Theme 2) Educational governance and leadership			
GP2.1	**Appropriate system for raising concerns about education and training within the**		

	organisation The visit team heard from the senior management meeting that there were good conduits for trainees to raise concerns about training and education. The SMT cited the regular junior doctors' forum where trainees could meet with members of the SMT and that this had been effective in addressing issues, such as equitable phlebotomy cover across the Trust. None of the trainees the visit team met with had attended the junior doctors' forum and stated that this engaged with foundation trainees but not the higher-grade trainees. The visit team also heard that all the departments had local faculty group (LFG) meetings. The GP trainees confirmed that these meetings occurred but that the GP trainees, the visit team met, did not attend. The visit team did however hear from consultants in care of the elderly that GP trainees had attended the local faculty group meeting but had not given much feedback. The visit team was pleased to hear that the consultants wanted GP trainees to provide feedback and had developed an approach where by a care of the elderly higher trainee met with the GP trainees collated the feedback and then presented it to the consultants at the LFG. The consultants stated that this approach would continue because it had generated more feedback. There was no forum for GP trainees to discuss training issues, amongst themselves, except at the weekly GP teaching. However, trainees did state that the programme directors were very approachable and supportive. The visit team heard that because the GP trainees' educational supervisors were based in general practices, not the Trust, the trainees would escalate issues to either the designated clinical supervisors, or more commonly, the programme directors for GP. The trainees, the visit team met, stated that the programme directors were supportive and responsive. The visit team heard that the educational supervisors wanted the trainees to be more empowered to raise issues in the Trust setting, rather than with themselves, because this would be more effectual as the educational supervisors were located externally to the Trust. None of the trainees, the visit team met with, reported using the educational supervisors as a feedback channel for training issues in the Trust. The programme directors corroborated this. However, the visit team found that there were currently limited opportunities for strategic communication between the postgraduate medical education team and the GP programme directors, which limited the effective responsiveness of the programme directors to the trainees. One of the difficulties encountered was that the director of medical education could not attend the weekly meeting where training issues were discussed by the programme directors.	The Trust is required to encourage GP trainees to use existing conduits for feedback on training but also to implement a local faculty group for GP trainees across the Trust. The Trust is required to facilitate strategic communication with GP TPD and the medical education team.	Mandatory Requirement Mandatory Requirement
GP2.2	**Organisation to ensure access to a named clinical supervisor** The visit team heard that trainees were given named clinical supervisors but the efficiency with which this was done varied between departments. The trainees stated that some clinical supervisors did not always understand the roles and training needs of the GP trainees. This also affected the ability of trainees to have workplace-based assessments completed.	The Trust is required to ensure that all GP trainees receive a clinical supervisor in a timely fashion who is aware of the GP trainees' learning needs.	Mandatory Requirement

GP2.3	**Organisation to ensure access to a named educational supervisor** The visit team heard that the programme directors had been disappointed regarding the GMC NTS results for educational supervision. It was suggested that this might have been because the educational supervisors for the ST1 and ST2 trainees were situated in the GP practices and not the Trust. This would have made arranging face-to-face meetings more difficult. The visit team met with the educational supervisors and, who confirmed that the contact between trainees in Trust posts and educational supervisors was limited because for the difference in locations. The visit team heard that it was probably because of the lack of proactivity amongst the educational supervisors to arrange these meetings. The educational supervisors did state that it was left to the trainee to arrange an initial and end meeting. This was corroborated by the trainees, who also confirmed each one had a named educational supervisor.	The Trust is required to ensure that educational supervisors are meeting with the trainees on a regular occasion and that this is timetabled into the trainees' rotas, three times per the trainees' rotation. The organisation of the meetings should fall within the remit of the educational supervisors, not the trainees.	Mandatory Requirement
GMC Theme 3) Supporting learners			
GP3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The majority of GP trainees stated that there had not been incidences of bullying and undermining. However, the trainees reported that the environment of the emergency department did not always encourage trainees to ask for support and advice.		
GP3.2	**Access to study leave** The visit team heard that acquiring study leave in paediatrics could be quite difficult. Other departments were said to be good for acquiring study leave but the gaps in the rotas could impede this.		
GMC Theme 4) Supporting educators			
GMC Theme 5) Developing and implementing curricula and assessments			
GP5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team heard from the programme directors that feedback from trainees in care of the elderly was polarised. Some trainees enjoyed the high workload as it produced many learning opportunities while others disliked this and could not manage. The programme directors were aware that there needed to be a balance between workload and training opportunities but that this had been made difficult because of the unavailability of locum doctors. The visit team heard that there were five care of the elderly wards with the patients assigned to different consultants. The foundation and GP trainees were then assigned to a consultant's patients. However not all consultants had foundation and GP trainees assigned to them and the GP trainees' role could be viewed as on a par with the foundation trainees'. As a result, the GP		

	trainees could find themselves undertaking a high workload, which had little educational value. The programme directors were unaware if trainees in care of the elderly were able to attend clinics regularly. The visit team found that there was a disparity between the consultants and GP trainees in care of the elderly regarding the trainees' ability to attend relevant clinics. The trainees stated that clinics were not included into the timetables but trainees were encouraged to go by the consultants. The trainees stated that there were missed learning opportunities regarding missed clinics especially regarding the stroke clinic. The consultants corroborated the fact that trainees did not attend the stroke clinic but presented to the visit team a timetable of clinics and names of the consultants and how that corresponded to each trainee. The programme directors stated that there were limited training opportunities of GP relevance within the GP post in urology, although the lead consultant for GP tried to maximise these. The GP trainee in urology confirmed that the post was more relevant to surgical than to GP training. The programme directors stated that the new consultant for T&O was driving a new approach for GP training and understood the learning needs of GP trainees. The visit team was pleased to hear from this consultant in another session that there was bespoke, GP orientated teaching in T&O and that the consultant had worked to ensure trainees were able to attend clinics and theatre lists. The consultant did however concede that there was still a lot of ward work that GP trainees undertook. The programme directors stated that the new T&O consultant was being supported by other consultants in the department and were confident this would be a sustainable and substantial change in culture for the department. The GP trainees in T&O stated that the post would be relevant and useful for GP training. The visit team heard that trainees were able to attend more of the clinics, although trainees were not aware of any formal, organised local teaching. However, because of a shortage of staff trainees were unable to optimise the learning opportunities available. The trainees in GUM stated that the post was very applicable to GP and there were lots of learning opportunities and clinics. Trainees did however state that the posts never allowed attendance at the weekly GP teaching. The consultants in paediatrics stated that the department viewed the GP trainees, as normal paediatric trainees because all the work GP trainees would undertake within the department would be relevant to GP training. The consultants did concede that the ward work might not always be as relevant but there was a good proportion of learning opportunities and ward work. The GP trainees, the visit team met, corroborated this, but that there could be more GP relevant teaching. The dermatology consultants stated that the GP trainees were a good addition to the department and would be happy to have additional trainees. The work of the department was relevant to the GP trainees' learning needs and the department asked for feedback from trainees at the end of the posts to ensure there were no training issues. Psychiatry trainees reported the post to be applicable to GP training, with lots of learning		

	opportunities, teaching and trainees were released to weekly GP teaching.			
Good Practice		**Contact**	**Brief for Sharing**	**Date**
The care of the elderly department used a trainee as a “deputy college tutor” as additional and confidential conduit for trainees to raise concerns and issues about training. This had seen a marked increase in feedback.		DME	Please fill out case study form.	
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 Rebecca Torry, Associate Director GP Specialty Training, Health Education South London			
Date:	25 February 2016			