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Quality and Regulation Team (London and South East)

North Middlesex University Hospital NHS Trust

Core Surgery, General Surgery Trauma & Orthopaedic Surgery and Urology Specialty Focused Visit

Quality Visit Report

15 March 2016

Final Report

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Visit Details	
Trust	North Middlesex University Hospital NHS Trust
Date of visit	15 March 2016
Background to visit	London School of Surgery had not formally visited the Trust for almost six years and concerns had been raised by trainees during their Annual Review of Competence Progression (ARCP) regarding the challenging training environment at the North Middlesex University Hospital (NMUH). The visit team was aware that due to the reconfigurations of services within the area as a result of the Barnet, Enfield and Haringey (BEH) clinical strategy, there had been a significant impact on services at the Trust and the visit team was concerned about the consequent impact on surgical training. During the Care Quality Commission (CQC) inspection in June 2014, it was found that the BEH strategy had affected the services with increased workload and extra pressure on patient care. The CQC found a significant increase in patient numbers across the board and whilst the Trust had done well in absorbing the increased numbers of patients; its infrastructure, staffing levels, training provision, complaints handling and governance were stretched and as a result this may have impacted on surgical training. The visit team was informed of the training holiday for anaesthetics trainees since 2015 implemented by the London School of Anaesthesia and was keen to explore the bearing this has had on the surgical training as well as patient safety within NMUH. The visit team heard that the urology training was good but was concerned that the above had had some impact on urology training as well. It was recognised that the Trust had the potential to be an excellent training environment with the richness of clinical cases available for surgery and the visit team was keen to explore how this could be facilitated.
Visit summary and outcomes	The visit was well attended and the visit team was impressed by the willingness the educational supervisors showed in wanting to train surgical trainees. The endoscopy department was described as providing a rich learning environment for surgical trainees and the visit team heard that the trainees achieved their Joint Advisory Group (JAG) accreditation before they left the Trust. The visit team also heard that all clinics were consultant led and trainers were always available, as well as approachable. Some good clinical examples were provided with trainees reported having undertaken breast reconstruction and the urology department making provision for additional theatre operating time during the week. It was also commendable to hear that the urology department was actively engaging with a lot of specialty paediatric and stone surgery. The visit team learnt that the trauma and orthopaedic department had a good exposure to trauma and elective surgery. The visit team was impressed with the engagement that the trauma and orthopaedic educational supervisors had shown by conducting a bespoke training survey to assess the training needs of trauma and orthopaedic trainees. However, the visit team heard that although the trauma and orthopaedic training was good, the structure of the departmental supervision was not very well organised. It was reported that there was a mismatch of the assignment of trainees to a pair of supervisors whose operative as well as outpatient lists often clashed with the trainees' job plan, therefore limiting the opportunities for direct supervision and training. The visit team heard that the trauma and orthopaedic rota was neither transparent nor communicated within a timely manner. Many trainees reported that the rota was currently only being communicated the Friday afternoon before the Monday week and there was no flexibility to negotiate time off. It was reported to the visit team that the trauma and orthopaedic trainees were attending more than three clinics per week which limited their time in theatre. The visit team was also informed that the minimum requirement of access to operative lists within the urology department had not been met. The visit team noted that urology trainees did not have consistent access to urodynamic training, which was a training requirement. The visit team heard that the Trust, although very supportive and flexible, had not been able to provide protected emergency surgery session (CEPOD)

	time for trainees which resulted in trainees having to attend theatre during their 'zero hours' to complete their outlined educational requirements. The visit team also heard that the higher trainees spent their night shifts triaging within the emergency department which did not contribute much to their surgical training. The introduction of weekend operating on elective cases due to the lack of Day case surgery unit meant that training opportunities were being lost. The visit team was informed that there was an inconsistent delivery of departmental and Trust inductions. Although, there were areas of improvement that were identified during this visit, the visit team noted that the Trust had good surgical training potential and if the Trust worked closely with the recommendations, it could become an excellent training environment.

Visit team			
Lead Visitor	Professor Nigel Standfield, Head of London Specialty School of Surgery	**External Representative (T&O)**	Mr John Paul Murphy, Consultant Orthopaedic Surgeon (Northwick Park & Central Middlesex Hospitals)
Trust Liaison Dean	Dr Indranil Chakravorty & Dr Andrew Deaner, Trust Liaison Dean (London East and London North Central)	**External Representative (Urology)**	Mr Roland Morley, Training Programme Director for Urology (London South West)
Lay Member	Robert Hawker, Lay Representative	**Lead Provider Representative**	Mr Richard Bird, Lead Provider Representative (UCLP) as Core Surgery Training Programme Director
Scribe	Deepa Somarchand, Quality Support Officer, Quality and Regulation Team (London and South East)	**External Representative (General surgery)**	Professor Tim Allen-Mersh, Chair for the Regional Specialty Training Committee in General Surgery.
Trainee Representative (Core and General surgery)	Dr Richard Boulton, General Surgery Trainee Representative		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement type
GMC Theme 1) Learning environment and culture			
S1.1	**Patient safety** It was reported to the visit team that patients were not always prioritised appropriately for surgical procedures due to the limitation of access to operating theatres at night. It was reported that only	The Trust is required to review its undertaking of surgical work during the evening, as capacity	Mandatory requirement

	one operative room was operational in the night and there were a limited amount of theatre staff members available during the evening. As a result, there were instances whereby patients who could have been operated in the night had to wait for the next day. The visit team also heard that patients were not given the appropriate acute medical assessment during emergency triage and often the surgical trainees arrived to find acutely unwell patients in inappropriate locations for hours without appropriate initial medical assessment.	needs to match the service's needs. This review should confirm availability of theatre slots and whether patients are subject to inordinate waits. The Trust is required to revise its emergency pathway for surgical patients and confirm the pre-requisite initial assessment prior to the arrival of a surgical doctor.	Mandatory requirement
S1.2	**Serious incidents and professional duty of candour** No serious incidents were reported to the visit team. Trainees informed the visit team that during morbidity and mortality meetings (M&M), no serious incidents were stated nor discussed.	The Trust is required to regularly incorporate the learning from investigation or analyses of serious incidents during M&Ms.	Mandatory Requirement
S1.3	**Appropriate level of clinical supervision** The visit team was informed that there was always a consultant present at clinics. However, core surgical trainees reported that at times they felt over-supervised in operating theatres due to the large numbers of consultants at the Trust and the presence of additional (international) trainees which diluted their training opportunity. The core trainees were not taking any referral calls or involved in the initial assessment of new admissions. This was a lost training opportunity.	The Trust is required to ensure that there is a correct ratio of trainees and trainers to facilitate an effective learning environment with suitable supervision.	Recommendation
S1.4	**Responsibilities for patient care appropriate for stage of education and training** It was reported to the visit team that although the post in breast surgery was more suited for junior trainees, at the time of the visit it was occupied by a higher specialty training grade eight (ST8) trainee. However, the visit team heard that the department was aware of this and the training provided was being geared to cater for the higher level; as a result, the trainee had been exposed to sufficient amounts of breast reconstruction cases and two full days of operating time per week. The upper gastrointestinal (upper GI) trainer admitted that the operating training being delivered to the current ST6 trainee was not at the appropriate level of training as the post was meant to be for a ST4. Nonetheless, the visit team understood that the current trainee was occupying this post to complete certain missing competencies (log book requirements). Despite the visit team hearing that the exposure to laparoscopy and endoscopy training was prodigious within the Trust, the trainee reported that the lack of exposure to theatre time hindered the completion of the training logbook.	The Trust via Surgical College Tutor is required to closely monitor the training needs of individual trainees who are recruited beyond or below their training grade due to extenuating circumstances and ensure that the training requirements are delivered without compromise.	Mandatory Requirement

S1.5	**Rotas** It was reported to the visit team that the trauma and orthopaedic (T&O) surgical trainees were attending more than three clinics per week, which limited their time in theatre. They reported that they rarely managed a case from beginning to end. Trainees reported that this had led to a loss of training opportunities and an inability to complete all their required competencies. The higher general surgery trainees reported that due to being scheduled for theatre on alternative weeks, they were struggling to complete all of their required training competencies, as they did not have enough exposure to operating time. It was reported to the visit team that on a monthly average there would be 16 half-day operating lists, which had to be shared among 11 higher trainees. Higher general surgery trainees reported attending only one all day list on a six monthly average as there were too many people on the rota. The visit team heard that there was no protected emergency operating session (CEPOD) for all the surgical trainees and as a result, they often attended theatre during their 'zero hours'. The visit team was informed that the T&O rotas including on-calls were sometimes released on the Friday evening of the Monday start, which made further planning difficult. There was no flexibility to the rota and the trainees felt that it was biased towards the trust-grade doctors. The urology trainee reported being allocated to only two half-days of theatre time per week and that there was no theatre dedicated to day care. The general surgery (breast) higher trainees appeared to be undertaking more than the recommended two clinics per week. General surgery trainees reported that their on call and night rota were dominated by work for the emergency department and as a result did not contribute much to their surgical training. The trainees also reported that they did not have any free time on their rota to attend extra theatre time. There was often a lag in processing trainees' request to be added to the endoscopy rota and this led to ineffective utilisation of available training opportunities. The core trainees commented that the rota was flexible and there were no problems in being released for central training.	The Trust is required to ensure that rota allocations are communicated at least six weeks in advance. Trust should also ensure that the allocation of rota correlate with training needs and trainees are given protected CEPOD time. All surgical trainees should attend a minimum of four half-day operating lists per week and no more than two clinics (plus one specialist clinic). Higher surgical trainees should be prioritised to operating theatre training over trust-grade doctors.	Mandatory requirement
S1.6	**Induction** The visit team was informed by the clinical director that trainees were provided with both a departmental as well as a Trust induction and they were asked to sign a form to acknowledge the delivery of these. However, the trainees throughout the surgical department fed back to the visit	Trust to ensure that all trainees receive Trust and departmental induction on arrival. There should be provision of an electronic version of	Mandatory Requirement

	team that there was an inconsistency in the delivery of the induction process whereby some received Trust induction and not departmental induction and vice versa. The visit team heard that the Trust did not have alternative delivery mode of induction if a trainee could not attend due to rota constraints. The visit team also heard that there was a departmental handbook available but it was not being effectively used in enhancing the familiarisation of trainees to their new department.	induction materials readily available to trainees who may not be able to attend scheduled induction times. Trust to deliver departmental handbook to all trainees at the start of each rotation to support the current departmental induction.	Recommendation
S1.7	**Handover** It was reported that the handover in the morning throughout all the surgical specialties was well attended and well presented. This was normally conducted at 8am with the presence of a consultant. The T&O trainees commented that the handover was always conducted in the same room, which made it easy for everyone to know where to be during that time. Higher general surgical trainees reported that the morning handover was also educational. However, the visit team heard that the night handover for general surgery was often delayed and conducted without a ward round. The team was informed that due to delay in shift handover of nurses, theatre time was at times missed.	Trust to ensure that the night handover for general surgery is conducted formally and consistently incorporating educational opportunities within.	Mandatory Requirement
S1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The visit team heard that there were many learning opportunities for trainees within all the surgical specialties; however, the educational and clinical supervisors reported there was a lack of engagement from trainees. Trainees commented that ES and AESs did not fully understand the Intercollegiate Surgical Curriculum Programme (ISCP). It was reported that there was a good exposure to paediatric and stone surgery within urology rotations but, due to the nature of the case mix and rota configurations at the Trust, trainees would have to acquire important curriculum coverage elsewhere. The visit team noted that the urodynamic training was not structured within the training programme when it was a required competency for urology training.	The Trust via the Urology training lead is required to ensure that Urology trainees have access to the full range of cases available relevant to the curriculum. This should be discussed and agreed at LFG. The Trust is required to ensure that there is a balance in the allocation of clinic (maximum two per week unless there is an additional specialty clinic) and theatre time (minimum four half-day sessions per week) so that trainees have the opportunity to complete their required competencies in time including access to urodynamic training. The Trust should specify and make provision for protected time for learning and/or organised educational sessions for all trainees as per curriculum.	Mandatory Requirement
S1.9	**Protected time for learning and organised educational sessions**		

	The visit team heard that the T&O trainees ran a 'metal work' learning session during clinic times on Monday mornings, which was well attended and supported by consultants.		
S1.10	**Access to simulation-based training opportunities** The visit team heard that the Trust had recently acquired a simulation suite, which was being used for surgical training. The trainees were also encouraged to attend simulation session at Royal Free London NHS Foundation Trust for laparoscopic colon surgery. It was also reported that trainees at the Trust had access to The London General Surgical Skills Programme provided by Imperial College London.		
S1.11	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** The visit team was informed that trainees felt well supervised throughout the day and the clinical supervisors were approachable. The trainees reported that the educational supervisors were readily available if needed.		
GMC Theme 2) Educational governance and leadership			
S2.1	**Impact of service design on learners** The visit team heard that despite the increase in staffing, there had been an increase in demand. Therefore, the Trust has recruited a considerable number of trust-grade doctors. This appeared to have led to trainees struggling to receive adequate theatre time. The visit team heard that the gynaecology team was not utilising effectively their assigned morning theatre time, which led to delayed theatre for the other surgical specialities and lost learning opportunities for trainees. The visit team was informed that there were skeleton nursing staff numbers available between 6pm and 8pm and there was only an anaesthetic on call doctor present after 10pm, which led to limited opportunities for surgical training in the evening and night. It was reported that despite the educational supervisors recognising that a day-case unit was a pivotal part of surgical training, no provision had been made to reinstate one at the Trust. Most elective surgical cases were scheduled for weekend; therefore, trainees were attending these during their 'zero hours' to gain the learning experience that they should have gained during the week. The visit team was assured that the 'training holiday' of anaesthetics trainees had not affected services as there was a good critical care outreach team who were accessible and collaborative with the surgical trainees. It was reported that there was a dysfunction in the manner surgical / T&O patients were referred	Trust should review opportunities for extending operating lists during the weekdays so training opportunities are optimised. Consider the re-introduction of a day-case unit which is an important part of surgical training and which would allow trainees to maximise their weekday training time rather than having to come into work on their zero days to take advantage of training opportunities.. Trust is required to review the pathway and protocols for referral of T&O patients to the	Recommendation Mandatory

	from the emergency department to the fracture clinic as well as to the emergency surgical trainee.	fracture clinic and ensure that appropriate guidelines or agreed criteria are followed. Higher surgical trainees should not be used to triage patients in the ED.	Requirement
S2.2	**Appropriate system for raising concerns about education and training within the organisation** The visit team heard that trainees were aware of the Datix reporting system but had not really used it. The trainees reported to the visit team that they had raised concerns in regards to increased numbers of non-training grade doctors as well as the number of higher trainees present on rotas, which limited their time in theatre.		
S2.3	**Systems and processes to make sure learners have appropriate supervision** It was reported by the educational supervisors that the urology department was working towards increasing extra sessions for consultants to be able to train urology trainees during the week. The department was also reported to be working towards creating more operating lists during the week to maximise training opportunities.		
S2.4	**Organisation to ensure access to a named clinical supervisor** T&O trainees also reported that they had experienced a disjointed training practice, as they were not assigned to the same consultant supervisor for theatre and clinics.		
S2.5	**Systems and processes to identify, support and manage learners when there are concerns** The visit team heard that the breast surgery team met every week to discuss any concerns and balance service needs with training needs. The higher trainees reported meeting every Friday to discuss learning and once a month the M&M meeting was incorporated within these meetings. The educational supervisors reported that every three months a Local Faculty Group meeting took place and a trainee representative had been appointed to attend these meetings. The Trust also held a monthly risk governance meeting.		
GMC Theme 3) Supporting learners			
S3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team heard that the T&O trainees felt segregated from the non-training grade doctors and that there was no camaraderie within the department. The trainees reported that they felt	Trust is required to ensure that there is a predictable, fair and transparent process in how	Mandatory requirement

	undermined by the alienation that the non-training grade doctors portrayed towards them. It was reported that the inflexible attitude of the rota coordinator, who was also a senior trust-grade doctor, further undermined the T&O trainees.	rota is allocated and distributed at least six weeks in advance. If inter-departmental behaviour becomes challenging and likely to impact on staff morale and patient care, support should be sought from Professional Support Unit (John Launer).	
S3.2	**Academic opportunities** The visit team heard that the core surgical trainee was undertaking a master's degree in vascular surgery and that the T&O educational supervisor actively encouraged their trainees to participate in research and audits. The visit team also heard that trainees reported completing their JAG accreditation before leaving the Trust. However, T&O trainees reported that they had to conduct audits and research in their own time as there was no protected time assigned for research.	Trust should allocate dedicated time in job plans for trainees to undertake research and/or academic activity.	Recommendation
GMC Theme 4) Supporting educators			
S4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The visit team heard that trainers also had access to The London General Surgical Skills Programme provided by Imperial College London.		
GMC Theme 5) Developing and implementing curricula and assessments			
S5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The visit team heard that within core surgery, trainees were well supported by their educational supervisors and were provided with a flexible rota so as they could achieve the surgical competencies required for their level of training, despite not having protected CEPOD time. The higher surgical trainees, on the other hand reported that they were not in receipt of enough theatre time despite the alternative week operating list and the pairing with another consultant's operating list on alternative weeks. As there was a low amount of surgical inpatients and a high number of trust-grade doctors, higher trainees found it difficult to gain sufficient practical experience to complete their required competencies. The higher trainees also reported that they were currently resident-on-call and this resulted in a loss of training opportunities due to rostered off-days.	The Trust via Surgical college tutor is required to ensure that rotas are designed such that higher trainees are not required to be resident on call.	Mandatory Requirement

S5.3	**An educational induction to make sure learners understand their curriculum and how their post or clinical placement fits within the programme** The clinical director reported that the Trust had a formal induction and trainees were asked to sign to evidence that they received the appropriate induction. However, trainees reported that they did not discuss their education needs and clinical placements with their educational supervisors and were not clear of their future training. This was emphasised by the lack of knowledge the educational and clinical supervisor expressed during the visit in regards to the General Medical Council recognition and approval of trainers (GMC R&A) regulation.	Trust is required to ensure that all educational trainers are accredited with the GMC R&A and opportunities for refresher training are readily available. Trainers should also be formally appraised by TPD / DME as a minimum once every three years.	Mandatory Requirement
S5.4	**Opportunities to develop clinical, medical and practical skills and generic professional capabilities through technology-enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation** It was reported that the Trust made use of a mobile simulation programme in theatre to advance the learning opportunities for surgical trainees. However, it was also reported that the information technology at the Trust was somewhat outdated and hindered e-learning. T&O trainees reported that the new technology within the fracture clinic had been more limiting as it was not a complete system and trainees were finding it difficult to embrace the new technology.	Trust should work with users to enforce a more user-friendly system or ensure adequate training is provided before new technology is introduced to a unit.	Recommendation
S5.5	**Opportunities for inter-professional / multidisciplinary working** The visit team heard of good opportunities for multidisciplinary working with the pairing of different surgical trainees.	Trust to develop a multidisciplinary working environment with the help of focus groups. Trust is encouraged access the PATHs programme. See Ref TWR 1.6 on action plan.	Recommendation.

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:	Professor Nigel Standfield
Date:	13 April 2016