Health Education England

St George's University Hospitals NHS Foundation Trust

GMC National Training Survey Results 2018

Risk-based Review (education lead conversation)

Quality Review report

13 September 2018

Final

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Quality Review details

Background to review	The purpose of the review was to discuss the Trust's General Medical Council National Training Survey results for 2018, with particular focus on the following specialties: • Anaesthetics • Cardiology • Cardio-thoracic surgery • Otolaryngology.
HEE quality review team	Professor Geeta Menon Postgraduate Dean Health Education England (South London) Dr Anand Mehta Deputy Postgraduate Dean Health Education England South London Paul Smollen Deputy Head of Quality, Patient Safety and Commissioning Health Education England (London and Kent, Surrey and Sussex) Louise Brooker Quality, Patient Safety & Commissioning Team Health Education England (London and Kent, Surrey and Sussex)
Trust attendees	The review team met with educational leads from each of the relevant specialties and the following representatives from the Trust: • Medical Director • Director for Medical Education • Associate Directors for Medical Education • Education Business Manager • Care Group Lead for Vascular Surgery.

Conversation details

Item	Summary of discussions	Action to be taken? Y/N
1	**Introduction** The Health Education England (HEE) review team thanked the Trust for facilitating the review and for the action plans and updates provided. Prior to the review date, the decision had been made by HEE, working with colleagues at the Trust, the General Medical Council and NHS Improvement, that three cardiothoracic surgery trainees working in the cardiac surgery service should be moved to other Trusts and that their posts be temporarily suspended. A meeting was held immediately prior to the review to discuss this action and the issues within the cardiac surgery service. A separate report was written following this meeting, therefore cardiothoracic surgery was discussed at the review only in relation to the other specialties reviewed.	

2	**Otolaryngology** The review team heard that the issues raised by the General Medical Council National Training Survey 2018 (GMC NTS) data were mainly at foundation and core level. One challenge had been ensuring appropriate clinical supervision for trainees in the 'SOS' emergency clinic (for patients requiring an appointment within 48 hours of referral) while reducing consultant presence in clinic to allow more time for training. The department planned to hold 30-minute case reviews between the consultant and trainee prior to each clinic, followed by a debrief session at the end of the clinic. The consultant would indirectly supervise the clinic as most cases were straightforward and could be managed by trainees. Higher trainees were responsible for holding the bleep and taking referrals, leaving junior trainees free to run the clinic. The night shifts were covered by surgical nurse practitioners, so trainees only worked on day shifts. The department had introduced meetings each Monday morning where consultants discussed the junior trainees and their working patterns so that the consultants had a greater awareness of when trainees were pulled to work on wards. The consultants also ran weekly teaching sessions. These additional efforts to support the core and foundation trainees had impacted on the opportunities available to the higher trainees, but the supervisors felt that this had not been detrimental and that overall trainee satisfaction had improved. There were rota gaps as not all trainees worked full-time. The gaps were covered by regular locum doctors and there was a medical training initiative (MTI) trainee in the department who was due to commence participation in the on-call rota following completion of the induction programme and necessary competencies. This was the second MTI trainee to be placed in the department and the review team heard that the scheme worked well and there were plans to host more MTI trainees in future. Across the Trust it was estimated that there were around 20 MTI trainees working in other departments. The review team advised that having a dedicated educational lead for MTI trainees and non-training doctors could help to improve the experience of these groups and make the posts more attractive during recruitment. Trust and departmental induction for new staff had been reviewed and updated. The Trust induction was run twice per year and included both doctors and nurse practitioners. The department induction had become more clinically focused to ensure that all trainees learned the necessary skills to perform more common procedures. The Director of Medical Education (DME) reported that this additional training had been well received but that it had not been possible to book all of the new trainees onto it due to a delay in receiving the trainees' details from the healthcare education team at HEE. The review lead noted that the systems for recording and sending trainee information were due to change and that Trusts would be given appropriate advance notice in future. Due to the different rotation dates for the various trainee groups there were new trainees in the department approximately every eight weeks. Trainees were directly supervised in clinic by a consultant at first until it was ascertained that they were competent to perform procedures with indirect supervision.	
3	**Cardiology** The review team noted that the GMC NTS results for cardiology had changed significantly from 2017 to 2018. Additionally, there was concern that the cardiology	

	trainees should be protected from the impact of the cultural issues and removal of trainees from the cardiac surgery service. It was reported that rota gaps at junior trainee level had impacted on trainees' experience in the past year. The Trust had attempted to mitigate this by increasing the level of consultant support and bringing in physician associates (PAs) to help manage the workload at junior level. Recruitment to the vacant posts had been unsuccessful. Following consultation with the trainees, the Trust had altered the rota to include an additional higher trainee, equivalent non-training grade doctor or consultant from 13:00 to 17:00 on weekdays and an additional junior trainee on Saturday and Sunday mornings. At the time of the review, the Trust had successfully recruited to the vacant posts and the rota was expected to be covered by the end of September 2018. The night on-call rota was due to change following the removal of cardiac surgery trainees. At the time of the review the trainees on the on-call rota worked one night in 13 and the department was looking at the impact of the reduction in trainee numbers. The review team heard that the department employed nurse practitioners (NPs) as well as PAs. The Trust had formed a workforce planning committee to review staffing solutions and there were business cases in development to increase non-medical staffing cover out of hours and introduce two new PA posts. There had been a prescribing pharmacist working in cardiology, but this post was to be moved to another department. The review lead informed the Trust that HEE was planning a conference to discuss advanced clinical practice and apprenticeships in November 2018. The review team heard that the department planned to alter the arrangements for trainees in clinics. The trainees had given feedback that they wanted to do one clinic per week, rather than the two or three clinics run by the consultants. The department was liaising with the specialty school to determine the correct balance of clinics and other work for trainees in each subspecialty. When consultants were on leave, clinics were run by specialty trainees at level six or seven (ST6 or ST7) without supervision. It was reported that some consultants met with trainees to plan the clinics in advance. If this was not possible, the trainee would be informed of which other consultant clinics were running on the same day so that they knew where to seek advice or assistance if needed. The department planned to start cancelling clinics when consultants were not available if trainees were not confident to run them independently, which would reduce the clinic burden and improve supervision. The consultants felt that the ST6 and ST7 trainees were competent to run clinics but that some ST5s lacked confidence to do this. The department planned to address this through the trainees' regular meetings with their ESs, to ensure that trainees did not feel pressured into running clinics before they were ready. Trainees had recently started attending the off-site blood pressure clinic, but feedback had been poor as it was logistically difficult to travel to the clinic and this prevented them from accessing other learning opportunities. The Trust planned to stop sending trainees to this clinic and was considering other options such as staffing the clinic with nurse practitioners (NPs). The NTS data around regional teaching was discussed. The review team was informed that trainees' rotas were planned or altered to allow them to attend training, including cancellation of clinics if needed. At the annual review of competency progression (ARCP) meetings trainees had reported attending 70% or more of regional teaching sessions. The GMC NTS data for local teaching and curriculum coverage was amalgamated so it was difficult to determine which trainee groups had	

	returned negative feedback for these indicators. The review lead advised that it was usual to receive more negative responses from junior trainees within cardiology and that higher trainees typically felt more satisfied with teaching. The department had a local faculty group (LFG) which met regularly. There was also a trainee forum where trainees could voice concerns to consultant representatives. The review team heard that the concerns raised at these meetings tended to relate to rotas and rota gaps rather than issues with teaching. The supervisors had been surprised about the NTS data around educational supervision. The department had held follow-up sessions with the trainees to discuss these issues further. The review lead advised that feedback to HEE indicated that trainees sometimes felt disconnected from their team or that they were not valued by the consultant in charge. The review lead acknowledged that this was a common issue in large departments where teams changed frequently and there were fewer opportunities for staff to build relationships. The department aimed to move towards a firm structure to help with this. The DME planned to meet with the consultants and consider ways to make ward rounds more training-focused and deliver teaching more effectively. The DME acknowledged that had become more challenging as activity in the department had increased.	
4	**Anaesthetics** The review team heard that there were separate educational leads for acute care common stem (ACCS) trainees, clinical fellows, ST4s and ST5s and above. All trainees and clinical fellows had ESs and there was a LFG meeting every two months which included trainee and clinical fellow representatives. Every six months the trainee representatives administered a survey and fed the anonymised results back to the department. The college tutors (CTs) attended the department meetings and there was a departmental improvement board. It was reported that there were 14 ST4s in the department and that most of the negative feedback in the NTS came from this group. Departmental survey data indicated that these trainees felt the environment in the intensive care unit (ICU) was not supportive and ICU rota arrangements made it difficult to swap shifts or arrange to attend training. The department was addressing these concerns by working with the ICU care group lead. It had been agreed that trainees should be released for teaching without needing to swap shifts and the department had sent out communications to this effect. Other issues reported by the ST4s included tensions between the ICU and anaesthetics staff, lack of specific inductions for each rotation and insufficient time in theatre compared to the amount of time spent on-call in ICU. Some ST4s had reported that the consultants treated them as novices. It was suggested that this was partly due to the size of the department and the small number of ACCS trainees in comparison to the number of consultants, leading to the ST4s being expected to carry out junior trainee work. The ST5, ST6 and ST7 trainees mostly expressed concern about the lack of exposure to emergency theatre work. When trainees covered the emergency on-call rota, they frequently split their time between emergency theatres, the maternity unit and multiple	

	trauma calls, meaning that they were not able to follow cases through. These trainees echoed the feedback from the ST4s about the difficulties caused by the ICU rota. The Trust had reviewed the trainee feedback and was working to improve overall satisfaction in several ways, for example by introducing dedicated rest areas for trainees, fixing rotas in some areas to enable trainees to plan their personal commitments and arranging for trainees to take taxis home after busy shifts when they had worked late. Induction was being redesigned to allow for more rotation-specific information and more face-to-face sessions, with information available electronically for reference. The emergency on-call bleep arrangements were to be altered so that trainees covered specific areas or specialties rather than responding to bleeps across the whole hospital site. The CTs acknowledged that in the emergency department (ED) trainees sometimes had difficulty deciding whether to escalate concerns via the anaesthetics or emergency medicine consultants. Trainees faced a similar situation in ICU, where they worked with the ICU team but were not part of it. The Trust planned to review and clarify the working arrangements and escalation pathways for the three departments. It was noted that the proportion of time spent in each area did not correspond to the numbers of assessments and competencies to be completed, which sometimes led to pressure on trainees to achieve multiple competencies in a short space of time. The review team asked about workforce transformation plans within anaesthetics, in light of decreasing numbers of operating department practitioners and the need to improve interdepartmental working between anaesthetics, ED and ICU. The department was considering developing anaesthetic nurse roles and an ICU outreach team, but proposals had not been submitted at the time of the review. It was noted that the NTS data around feedback was significantly worse than in previous years. The review team heard that anaesthetic trainees working in paediatrics, cardiology and neurology had the opportunity to give feedback at a daily forum, but that this had not been received well. In addition to LFGs and local surveys, trainees gave feedback when completing workplace-based assessments. Trainees were encouraged to submit exception reports but only one had been submitted in the past year. The review lead advised that anaesthetic trainees could continue to attend cardiothoracic theatres during cardiac surgery procedures, as there was always an anaesthetic consultant to manage these cases and trainees were supernumerary. The anaesthetics department was monitoring trainees' experiences in cardiothoracic theatres through the trainee forum and no concerns had arisen at the time of the review.	Yes, please see NTS4

Next steps

Conclusion
The review team noted the progress made by the Trust towards addressing the concerns arising from the GMC NTS 2018. HEE planned to conduct separate reviews of the following specialties to explore the issues raised in more depth and monitor the improvements being made by the Trust: • Otolaryngology, including general practice trainees

- Anaesthetics
- Cardiology.

Requirements / Recommendations

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
NTS 4	The Trust should ensure that anaesthetists working in cardiothoracic theatres are aware that trainees should be directly supervised at all times.	Please provide trainee feedback demonstrating that anaesthetics trainees in cardiothoracic theatres are always directly supervised by consultant anaesthetists.	R1.8

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
	None		

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
None	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Geeta Menon
Date:	23 October 2018

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.