

Visit to Cambridge University Hospitals NHS Foundation Trust

This visit is part of a regional review and uses a risk-based approach. For more information on this approach see the [General Medical Council website](#).

Review at a glance

About the visit

Visit dates	03 November 2015
Site visited	Addenbrookes Hospital
Programmes reviewed	Undergraduate: Cambridge School of Clinical Medicine Postgraduate: Anaesthetics, intensive care medicine, general surgery, plastic surgery, obstetrics and gynaecology (O&G)
Areas of exploration	Patient safety, balance between service delivery and training, induction, handover, medical education, organisation management and leadership, quality management processes, rotas, placements and curriculum delivery, equality and diversity, support for students and doctors in training, including supportive environment, student assistantships and preparedness of F1s, training and support for trainers, educational resources.
Were any patient safety concerns identified during the visit?	Yes

Concern	<p>There was a potential serious concern with the management of theatre which could have had an impact on patient safety and led to a negative effect on training. Emergency surgery had been delayed so that surgery occurred in the 'out of hours' period. This potentially left the trainees (particularly core trainees) with less support and little opportunity to gain worthwhile theatre experience.</p>
Action taken	<p>The concern was reported to the senior management team at Cambridge University Hospital at the end of the day on 3 November 2015.</p> <p>The trust were asked to investigate this concern further and undertake a risk assessment on the management of theatre at the hospital, to establish whether it is having an effect on patient safety and the quality of training.</p> <p>The trust responded by conducting a thorough investigation into the matter. We are satisfied with their response and recognise that the management of theatre is not a patient safety issue. However, there has been an impact on the quality of training. Senior managers have a suitable action plan in place to increase theatre capacity at the trust; to modify workload and to ensure appropriate level of cover for surgery both in hours and out of hours for doctors in training.</p>
Were any significant educational concerns identified?	<p>No</p>
Has further regulatory action been requested via enhanced <u>monitoring</u>?	<p>No</p>

Summary

- 1** Cambridge University Hospitals NHS Foundation Trust consists of two sites: Addenbrookes and the Rosie Hospital. The visit was held at Addenbrookes. This is a large hospital which delivers care in a number of specialties, including some areas of medicine which are not available at many other locations in the country.
- 2** Following a recent CQC inspection, Cambridge University Hospitals NHS Foundation Trust was judged to be inadequate. Consequently, there have been changes in senior management and at the time of the visit there was an acting Chief Executive in place. Cambridge University Hospitals NHS Foundation Trust aims to be a place of great innovation and excellence in health and care. They deem their key priorities to be a trust which offers person-centred and clinically excellent care. The trust is experiencing financial pressures, which could have an impact on the quality of training, but senior managers are working to mitigate this.
- 3** We visited Cambridge University Hospitals NHS Foundation Trust as part of our regional review of undergraduate and postgraduate medical education and training in the East of England. During the visit we met with foundation doctors, and core and higher specialty doctors in training in anaesthetics, plastic surgery, intensive care, O&G, and surgery. We met students in years five and six of the clinical course at the University of Cambridge, School of Clinical Medicine. We also met with educational and clinical supervisors, the education management team and senior managers at Addenbrookes.
- 4** Overall, we found that the LEP was committed to education and training. Students and doctors in training were well supported. The trust has many initiatives to enhance the training experience of doctors and medical students such as the Chief Resident Programme, which was highly commended by doctors in training. We did have concerns about the management of theatre and its impact on patient safety and the quality of training. We identified further concerns with induction, rota gaps, handover, and the consistency of teaching.

Areas of exploration: summary of findings

Patient Safety

The majority of doctors in training and undergraduate students that we met are clear about the procedures to take to report any patient safety issues. Furthermore, patient safety issues are disseminated across the trust to share good practice and to learn from each case. The trust is currently introducing a new patient safety reporting system (QSiS), which students and

doctors in training will use to report concerns. During our visit, it was too early in the implementation of the QSiS system to evaluate its impact.

We are concerned about the clinical governance of the Intermediate Dependency Area (IDA) in regards to patient safety. This is because the IDA acts as an intermediate ward, and therefore obstructs the consistency in patient care.

Doctors in training reported that the IDA contains very sick patients, but there is a lack of clarity amongst consultants, doctors in training and managers as to the clinical responsibilities for review and management of these patients. This leads to situations where junior doctors, often F1s or F2s, are left to monitor and manage these patients, sometimes with inadequate supervision. The Overnight Intensive Recovery unit also had a lack of staff available to care for these patients. Educational and clinical supervisors commented that occasionally staff in the recovery unit are not clear on who to call if they needed to escalate an issue.

See requirement 4

Supervision varies across the different specialties. In plastic surgery, each doctor in training is given an assigned educational supervisor who rotates every six months to enable a variety of experiences. In anaesthetics, core and higher specialty doctors in training stated that the supervisor they are allocated supervises them throughout their career. We met doctors in training performing elective surgery who stated that they had a clinical supervisor who oversees their clinical work, but during out of hours they are sometimes left to work on their own. However, they did not feel that they were working beyond their competence out of hours.

The terminology used to refer to foundation doctors and doctors in training is variable and could be a patient safety issue. The term 'Senior

	<p>House Officer (SHO)' was widespread and does not denote a particular level; it does not differentiate between foundation year two and core doctors in training.</p> <p>See requirement 7</p>
<p>Balance between service delivery and training</p>	<p>Educational and clinical supervisors told us that there are service pressures which do impact upon the quality of supervision and training they can offer medical students, foundation doctors and doctors in training. They have to work flexibly to ensure that they deliver service needs. The doctors in training we met reported that consultants often ask them to come out of hours to get further training and experience. They reported that they valued this opportunity.</p>
<p>Induction</p>	<p>The quality of the departmental induction for doctors in training is variable. Core trainees in general surgery reported that they did not receive an induction, whereas in anaesthetics induction is very well organised. Foundation doctors are given the opportunity to work shadow which worked as their departmental induction.</p> <p>See requirement 6</p> <p>The doctors in training we spoke to commented that the trust induction was good and very useful. Changes have been made to the trust induction to include an introduction to the EPIC system (internal clinical software). It takes longer than the allocated day induction to learn EPIC, however, the doctors in training we spoke to commented that in comparison to before, this is an improvement.</p>
<p>Handover</p>	<p>The quality of handover is variable across the different specialties. In intensive care, plastic surgery and acute internal medicine, handover works well; all foundation doctors and doctors in training commented that they are happy with the processes. In anaesthetics, there is no formal handover system, however, handover is</p>

	<p>consultant led. In general surgery, ward based handover involves written notes which are exchanged between foundation doctors. Therefore, it could be easy to miss things during handover.</p>
<p>Medical education organisation, management and leadership</p>	<p>Every consultant had time allocated in their job plan to train, assess and support doctors in training. They undergo suitable training for their role and are appraised. The willingness of trainers to offer educational experiences outside of their normal working day is a very positive aspect we observed.</p> <p>Undergraduate medical students commented that the quality of teaching is good. Regional teaching is valuable at Addenbrookes, although occasionally this was cancelled. Foundation doctors commented that teaching is not bleep-free, which means they can get interrupted. There is no opportunity for formal inter-professional learning; this occurs informally.</p> <p>Higher specialty doctors in training in plastic surgery commented that the training in Addenbrookes is excellent. Teaching, when it happens, is good but service pressures meant that this was not always accessible.</p>
<p>Quality management processes</p>	<p>The trust undergoes an annual quality assurance inspection by the Cambridge Clinical School of Medicine, which the education management team find very useful.</p> <p>If a problem is identified, for example, with handover or supervision, the managers at the trust intervene early and put in practices to guarantee an improvement. This process ensures issues are identified and resolved efficiently. Moreover, the Education managers we spoke to were aware that there is variability in the quality of training across the different specialties.</p> <p>Medical students, foundation doctors and doctors</p>

in training that we met reported that they are asked to provide feedback to the trust, which is used to improve the training and work practices. Some medical students commented that it was not always clear what impact their feedback had made and believed there is 'feedback fatigue' amongst the student body, who offer their views, but are not listened to. Senior managers state that they do use feedback from students and doctors in training to make improvements, and gave examples.

We were told that other data was not collated or analysed systematically to ensure improvements. Therefore, senior managers' local quality processes are not informed by a range of data such as staff and patient feedback and information from quality assurance visits; they rely heavily on student and doctor in training feedback.

See requirement 3

Rotas

We were informed that rota gaps do occur, although the education management team reported that this has improved. In anaesthetics, there had been a shortage of anaesthetists. This led to doctors in training running solo lists, which they perceived to be of little value for their training. However, staff shortages in other departments at Addenbrookes meant operations had been cancelled and this had alleviated the pressure.

In O&G, we were told that there are insufficient doctors in training, and those who are recruited are not senior enough to deal with complex cases. Additionally, in plastic surgery, there were insufficient consultants, so we heard that doctors in training are routinely working longer than their scheduled hours. At the time of the visit, we were told that external locums could not work at the trust because they are not EPIC trained.

See requirement 5

Placements and curriculum delivery

Educational and clinical supervisors reported that they have a good awareness of the Cambridge Medical School curriculum and have received sufficient information on how to carry out assessments. The Educational management team work closely with Cambridge School of Clinical Medicine to ensure that they are aware of the changes to the curriculum. The students we met felt their educational supervisors were knowledgeable of their different curricula and assessment requirements. Occasionally, students reported that their clinical supervisors were unsure about what aspects of the curriculum they needed to be taught but this did not affect the quality of the training. Every consultant had time allocated in their job plan to train, assess and support doctors in training. Consultants undergo suitable training for their role and are appraised.

The training opportunities on offer vary in quality according to the specialty, particularly at core and higher level. This is due to the imbalance between training and service delivery in some departments. In plastic surgery and anaesthetics, doctors in training are often on call to fill rota gaps.

The doctors in training we met stated that they appreciate the breadth of experience they get at Addenbrookes because they can see complex patients and cases that they could not see anywhere else. They stated that there is a great deal of good subspecialty experiences and opportunities.

We were told that there is a lack of theatre space at Addenbrookes which has an adverse impact on training. Doctors in training reported that emergency cases identified during the day are postponed or delayed. Therefore, the emergency cases are undertaken out of hours, which is in contravention with National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

recommendations. As a consequence of this, time is limited for senior surgical doctors in training over night as theatres are full. Furthermore, this situation potentially left the doctors in training (particularly foundation and core trainees) with less support and little opportunity to gain worthwhile theatre experience. In our meeting with educational and clinical supervisors, they confirmed this and explained that elective surgery can overrun, which delays emergency surgery.

Senior managers informed us after the visit that they have plans in place to increase theatre capacity at the trust. Senior managers have devised a new set up for emergency surgery within the trust so that they can ensure compliance with NCEPOD recommendations for out of hours operating.

See requirement 1

We were told that higher specialty doctors in training have more enjoyable experiences where they have scheduled time in theatre. This enables them to get good hands-on experience.

In addition, GP trainees commented that their experience is not always useful to them as it is too highly specialised. The GP trainees outlined that they are required to undertake work on the wards as there are insufficient numbers of doctors in training in some departments, such as in O&G.

See requirements 1 and 2

Clinical supervisors commented that they sometimes encourage doctors in training to come to Addenbrookes out of their normal hours to access the teaching and training they need. Doctors in training we met appreciated the consultants' willingness to do this and use this opportunity to access vital knowledge and experience.

We were told that not all doctors in training had protected time to attend clinics.

See requirement 2

The Chief Resident programme was praised by the doctors in training we met because of the way it helps develop their professionalism and enhances their leadership and management skills. Doctors in training told us that Chief Residents are an asset to the trust because they complete service improvement projects and they meet regularly with senior managers to feedback on pressures in the trust.

Good practice 1

The 'Hot Week Consultant' initiative is highly commended by doctors in training. This is where consultants in plastic surgery act as the main person that sees the patients regularly to allow doctors in training to engage in their training opportunities. Most consultants in other specialties were very keen to train and engage in initiatives like this but are unable to due to service pressures. The educational and clinical supervisors we spoke to also commented on the benefits of the 'Hot Week consultant' programme.

See Good Practice 3

Equality and diversity

All doctors in training we spoke to had received equality and diversity training. However, they commented that this training is not necessarily useful in practice.

Senior managers told us that there is an equality and diversity lead at the trust. However, the lead only gets involved with doctors in training if there is a specific equality and diversity concern raised.

Senior managers collate a range of equality and diversity information, however this is not analysed in sufficient detail to enable the detailed scrutiny of attainment and outcomes according to

various protected characteristics. No equality and diversity data is collated in regards to the trainers.

Recommendation 1

The undergraduate students we met commented that they do not receive much equality and diversity training. When learning about women's health, they receive minimal training on cultural issues, and what they do receive could be outdated.

Support for students and doctors in training, including supportive environment

The environment is supportive. Foundation year one, core and higher specialty doctors in training reported that all of the educational and clinical supervisors are very approachable. There is an open door policy which works well at the trust. Occasionally, the initial meeting between the doctor in training and their supervisor could be delayed, but when the meeting does occur, it is usually a success. The educational and clinical supervisors obtained excellent feedback from doctors in training for the quality of their supervision.

The education management team at the trust reported that there is a zero tolerance policy to bullying and undermining. They encourage all doctors in training and medical students to relay any concerns they have as early as possible to a member of the team.

Doctors in difficulty are given support from their educational and clinical supervisors in the first instance and if necessary, from the Postgraduate Dean for further pastoral support. Education managers also told us that they can refer cases to the Professional Support Unit (PSU) at Health Education East of England (HEEoE). Trainees who have had an illness that seriously affected their training or led to personal difficulties are referred to the PSU and they receive relevant support.

Student assistantships and preparedness	<p>Foundation doctors we spoke to told us that they felt prepared for their foundation training. They found the student assistantships they did as medical students helped prepare them aptly for their F1 year.</p>
Training and support for trainers	<p>Clinical and educational supervisors told us that they are well supported at the trust. We heard that trainers are appropriately trained and appraised.</p> <p>The trust has worked hard to ensure that trainers have sufficient time in their job plans to train, supervise, assess and provide feedback to support and develop doctors in training. Each consultant is already allocated 0.375 SPA and an additional 0.125 per educational supervisee. This is not always achieved but the SPA time is labelled for every consultant.</p>
Educational resources	<p>Doctors in training and medical students are pleased with the simulation and cadaveric facilities available at the trust. We noted that there is a real commitment at the trust to develop the excellent High Fidelity Medical and Surgical Simulation Centres.</p> <p>See Good Practice 2</p> <p>When the EPIC system was first introduced, some doctors in training and medical students did not have appropriate log on details for the system so they had to depend on colleagues to obtain vital patient information. This had a negative impact on the wards and on the quality of service for outpatients.</p> <p>Higher specialty doctors in training commented that until recently, the introduction of the EPIC system inhibited the availability of blood products, and observations were not being uploaded onto the system quickly because other</p>

computer systems were not compatible with the EPIC system. They were pleased that this issue has been rectified.

When we met with foundation doctors in training, they reported that the training they receive in EPIC is designed by the manufacturer and is not tailored to their needs as it is not task based. This led to it taking longer than expected for them to familiarise themselves with the EPIC system.

Furthermore, senior consultants find it difficult to use the system and the training offered does not sufficiently meet their needs. As a result, foundation doctors are sometimes asked to write a patient review on a consultant's behalf based on the consultant's brief summary. Foundation doctors reported that they find this uncomfortable.

Most medical students reported that they had now found that there are advantages to the EPIC system, because they can access all of the patient information in one place. They also appreciate the area allocated for senior students to write their notes.

See Recommendation 2

Areas of good practice

We note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further.

Number	Paragraph in <i>Tomorrow's Doctors</i> <i>The</i>	Areas of good practice for the LEP
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	<i>Trainee Doctor</i>	
1	TTD 6.16, 6.27	The trust's commitment to academic training and educational innovation which is exemplified through the Chief Resident Programme.
2	TTD 8.7	The excellent simulation and cadaveric facilities on offer to doctors in training at Addenbrookes.
3	TTD 6.10	Consultant 'hot week' which helps doctors in training to spend time on their actual teaching and training rather than their service commitments.

Good practice 1:

- 5** The Chief Resident Programme enables doctors in training to develop their leadership and management skills. All of the doctors in training involved in this programme commented on the vast opportunities available to them, especially the chance to complete a service improvement project. Senior managers at the trust outlined that a great advantage of this programme is the fact that chief residents act like an educational conduit between managers and doctors in training. This enables both parties to keep informed about issues affecting the trust.

Good practice 2:

- 6** Undergraduate students and postgraduate doctors in training highly value the simulation and cadaveric facilities available to them at Cambridge University Hospitals NHS Foundation Trust. The investment in these facilities has led to a great teaching resource for all who use it.

Good practice 3:

- 7** In plastic surgery, consultants do a "Hot week" where the consultant acts as the person that sees the patients regularly to allow trainees to engage in their training opportunities. Higher specialty doctors in training commented that this is an excellent initiative that enables them to use the time to meet their training needs.

Requirements

We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards. If these requirements are not met, we can begin to withdraw approval.

Number	Paragraph in <i>Tomorrow's Doctors The Trainee Doctor</i>	Requirements for the LEP
1	TTD 1.2	The trust must ensure that doctors in training are provided with support at all times when in theatre.
2	TTD 6.11	The trust must ensure the effective implementation of curriculum delivery to include structured outpatient and theatre sessions.
3	TTD 2.2, 2.3	The trust must introduce a structured, systematic process of collecting data other than student and doctor in training feedback to inform local quality control processes.
4	TTD 1.2	The trust must clarify the clinical governance of the Intermediate Dependency Area (IDA) to ensure the consistency of care for all patients in this unit.
5	TTD 1.5, 6.10	The management of rotas and current working practices must be reviewed to ensure compliance with Working Time Regulations. This will also ensure the release of trainees for regional teaching.
6	TTD 6.1	The trust must ensure that all doctors in training receive an appropriate departmental induction every time they start a new post or programme.
7	TTD 1.2	The out-of-date terminology used to refer to and identify doctors in training must not be used. The expected level of competence of different junior tier grades should also be communicated more clearly to the wider team.
8	TTD 3.5	Improve the collection and use of Equality and Diversity data relating to trainers and doctors in training to enhance the training experience for all at the trust.

Requirement 1: Ensure that doctors in training are provided with support at all times when in theatre

- 8** The lack of theatre space and the poor management of theatre has an impact on the quality of training at Addenbrookes. The doctors in training and the clinical supervisors we met told us that emergency surgery is at times delayed so that it occurs 'out of hours'. This left doctors in training with little support and little opportunity to gain worthwhile theatre experience. Senior managers investigated this after the visit and outlined that due to capacity issues with theatre, sometimes surgery was being delayed. However, senior managers have recognised the impact on training and have an action plan in place. This plan will ensure a reduction in the responsibilities for the senior doctor in training out of hours, and an increase in the contribution of senior clinical fellows to help with the on call workload. Furthermore, there are plans in place to increase theatre capacity. The trust should continue to audit the effect of the measures they have put in place to ensure sustained improvements.

Requirement 2: Ensure opportunities for structured outpatient and theatre sessions are provided for doctors in training

- 9** There is variability in the opportunities for doctors in training to access structured theatre and outpatient sessions to fulfil their training needs. In specialties like plastic surgery, theatre time is well organised and doctors in training told us that they are given ample opportunity to practice their skills. Educational and clinical supervisors from plastic surgery verified this. In other specialities, such as surgery and O&G, doctors in training told us that they are not given suitable time in clinics or theatre to advance in their training at a suitable pace. Senior managers state that there is a lack of sufficient theatre space and this has had an impact on training.

Requirement 3: Introduce the process of collecting data (other than student and trainee feedback) in a structured way to inform local quality control processes

- 10** Senior Managers focussed a great deal on feedback from students and doctors in training to quality manage teaching and training. However, they do not analyse sufficient data from other sources in a structured and systematic way. As a result, local quality control processes do not enable the senior management team to have a fully informed understanding of quality at the trust. Collecting and analysing a range of data, such as information from quality assurance visits, will aid senior managers in forming a suitable quality improvement strategy and a cohesive overview of medical education at the trust.

Requirement 4: Clarify the clinical governance of the Intermediate Dependency Area (IDA)

- 11** There was some disagreement amongst doctors in training and clinical supervisors regarding the management of the Intermediate Dependency Area (IDA), particularly

in regards to who was responsible for the care of patients. Some clinicians felt it was the responsibility of the team in the IDA, whereas others thought it was the team that was taking care of the patient prior to their transfer to the IDA. The trust must clarify which team is responsible for the care of patients who need to be transferred to the IDA. This would ensure consistency in patient care and suitable supervisory conditions for doctors in training in this situation.

Requirement 5: Ensure all rotas are compliant with Working Time Regulations (WTR)

12 A majority of doctors in training that we spoke to reported problems with rotas which are having an impact on their training. We were told that rota gaps were making it difficult for doctors in training to access study leave and to attend teaching sessions and clinics. Senior managers told us that there is tension between delivering service and good quality training, which they are working hard to mitigate, however they know there are issues outstanding. As a result of rota gaps, some doctors in training are working very long hours.

Requirement 6: Ensure that all doctors in training receive an appropriate departmental induction

13 Induction was raised as an issue in the documentary evidence we saw prior to the visit. In our meetings with foundation doctors and doctors in training, we noted that some of them had not received a departmental induction. Those who had received an induction commented that the quality of this is variable, with some being trained on all aspects including EPIC, and others being given just a brief oral introduction. This introduction lacked vital information about their role in the team. The foundation doctors and doctors in training we spoke to said they would benefit from an appropriate and consistent departmental induction every time they start a new post.

Requirement 7: The out-of-date terminology used to refer to and identify doctors in training must not be used. The expected level of competence of different junior tier grades should also be communicated more clearly to the wider team.

14 We noted that a range of doctors in training as well as educational and clinical supervisors that we met use the outdated term 'Senior House Officer' or 'SHO' when referring to levels of training. We also saw some core and higher specialty doctors in training using badges with the term. This could lead to confusion about the expected level of competence of the doctor in training, especially with other staff, such as nurses.

Requirement 8: Collect and analyse equality and diversity data for doctors in training and trainers

15 Equality and diversity data is not collated consistently during training for trainers and doctors in training. Therefore, aspects such as the recruitment and appointment of doctors in training or any differential attainment are not addressed. Furthermore, through a lack of sufficient data analysis, the quality of equality and diversity training is not reviewed systematically. Doctors in training report that their equality and diversity training is not useful as it is not relevant to their training in practice.

Recommendations

We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas, in line with best practice.

Number	Paragraph in <i>Tomorrow's Doctors/ The Trainee Doctor</i>	Recommendations for the LEP
2	TTD 8.2 TD 6; 160	Further develop the EPIC system in regards to training and usability to ensure that the system is fully embedded into hospital practice and staff are able to access and use the system with increasing competence.

Recommendation 1: Ensure the full integration of the EPIC system at the trust

16 We were concerned about the EPIC system because during the first couple of months when EPIC was being introduced, the system had a negative impact on service delivery, particularly in outpatient clinics and on the wards. Some students and doctors in training were not able to access the EPIC system and therefore could not access patient notes. Senior managers told us that this negative impact was expected due to the great change in moving from a paper based system to EPIC, but the impact was relatively short lived. Doctors in training and undergraduate students commented that the usability of the system has improved and they are becoming more confident with the system. However, further improvements are required to ensure that all members of staff and students continue to develop their confidence

and ability to use EPIC to its full potential. Training in EPIC is currently being evaluated, refined and reviewed.

Acknowledgement

We would like to thank the Cambridge University Hospitals NHS Foundation Trust and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.