Introduction

This report gives a picture of medical education and training across Yorkshire and the Humber in 2014–15. The findings come from our visits to seven local education providers (LEPs), three medical schools and one local education and training board (LETB) in the region.

Why did we choose Yorkshire and the Humber?

We selected this region because of:

- the length of time since we had last visited organisations in the region

- some issues of potential concern that had been raised through routine reporting, annual surveys and our enhanced monitoring process.

In 2014 we published a schedule of regional visits with the aim of visiting each region and country in the UK over a seven-year period. We visited Yorkshire and the Humber as part of this schedule.

What do we know about the region?

There are three medical schools in Yorkshire and the Humber – Sheffield medical school, Hull York medical school, and Leeds medical school. During the 2014–15 academic year, there were a total of 3,529 students across these three schools. The LETB – Health Education Yorkshire and the Humber (HEYH) – is the body responsible for managing postgraduate education and training across the region, and is accountable to Health Education England. 4,704 doctors are training in programmes across the region.

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† Enhanced monitoring is the process by which we support medical schools, deaneries and LETBs to resolve safety and quality issues in medical education and training. Issues that are subject to enhanced monitoring are those that we believe could adversely affect patient safety, doctors’ progress in training, or the quality of the training environment.

‡ The schedule is published on our website at www.gmc-uk.org/2014_2018_Regional_Visit_Schedule.pdf. Wales, the West Midlands and London are not listed as they were visited in 2012–13 and 2013–14.
What did we do?

To understand the experience of medical students and doctors training in Yorkshire and the Humber, we visited seven LEPs, three medical schools and HEYH between October and December 2014.

The map on page 3 shows the location of these organisations.

We chose the seven LEPs based on our own evidence and on information from our network of regional liaison and employer liaison advisers.*

We have well developed evidence about postgraduate training, and our annual survey of doctors in training has a very high response rate. This survey gives us a great deal of information on the quality of training across the UK. We also receive routine updates from LETBs and deaneries on their progress in addressing concerns they have identified through their local quality management processes.

We receive routine reports from medical schools. In spring 2014, before our visits, we also carried out a survey of medical students from the three medical schools to learn more about their experience at the medical school and while on their clinical placements at LEPs. The survey results provided further evidence for us to explore on our visits to each of the medical schools in November 2014. More than 750 students responded to our survey.

Our regional reviews consider several specialties and stages of training in more detail – we decide which ones based on the above evidence. For this review, we focused on the following training programmes:

- foundation
- emergency medicine
- obstetrics and gynaecology
- paediatrics.

During the visits, we spoke to medical students, doctors in training, their teachers and supervisors, and the management teams of the organisations. We also asked each organisation we visited to give us further information, before our visit, to help inform our review.

In this report, we have summarised the regional themes and listed areas working well and where improvements are needed. You can read the detailed reports of the visits at www.gmc-uk.org/regionalreviews.

* Regional liaison advisers work with doctors, patients, medical students and others across England to make sure we understand their needs, and to explain and discuss the work we do. Employer liaison advisers work with employers across the UK to create closer working relationships with the General Medical Council (GMC).
Introduction

Scarborough
Hull
Grimsby
Leeds
York
Halifax
Wakefield
Barnsley
Sheffield

York Teaching Hospital
NHS Foundation Trust
(split site)

University of York
(split site medical school)

University of Leeds

University of Hull
(split site medical school)

Hull and East Yorkshire Hospitals
NHS Trust

Barnsley Hospital
NHS Foundation Trust

Northern Lincolnshire
and Goole NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust

Mid Yorkshire Hospitals
NHS Trust

Sheffield Teaching Hospitals
NHS Foundation Trust

University of Sheffield

HEYH – headquarters

LETB

LEP

Medical school
Regional themes

Medical students benefit from strong academic and clinical support

In our survey of medical students, we asked about their academic and clinical experience.

We heard that assessment systems at each school are generally clear and students know what is expected of them when they are being assessed.

However, students want more detailed feedback on their performance in an assessment – for example, after an exam or an objective structured clinical examination (OSCE).

We also heard that learning about professionalism – the capabilities, behaviours and values expected of medical students and doctors working in the UK – is an important part of the course content.

Students told us they clearly understand the links between their basic science learning and their exposure to clinical practice and, when on clinical placements, they are supervised or given instructions before carrying out clinical procedures. This was reinforced on our visits to LEPs.

Case study: Teaching about professionalism at Leeds medical school

Throughout our visit, we heard that teaching about professionalism and patient safety forms a key part of the programme. The curriculum has been changed over the past few years to make sure that these features are consistently taught to students at all stages. The school has introduced a mandatory professionalism ceremony for third-year students, giving them the chance to celebrate their success so far. The school has also developed badges to recognise professional and committed students and staff.

Students told us that the ceremony helps to maintain motivation and is an extremely positive addition to the curriculum. Students in their third and fourth years said it reminds them of their responsibility to be professional, and fifth-year students said it was an important marker for the transition from university-based teaching to clinical teaching.
Staffing levels have a clear impact on education and training

HEYH is not alone in facing challenges in recruiting and retaining doctors. All seven LEPs told us about the adverse impact of reduced staffing levels on education and training, and reported having insufficient consultants or doctors in training in established posts. This makes it difficult for doctors in training to:

- achieve clinical competences
- complete and get their assessments signed off so they can progress to the next stage of training
- attend scheduled teaching, both locally and regionally.

Staffing shortages can also mean that doctors in training are vulnerable to working beyond their competence or without appropriate supervision as they respond to service pressures. This is especially challenging when services are delivered across split sites, and for doctors in foundation training who must have access to on-site supervision.

Case study: Supervision issues at Barnsley Hospital NHS Trust

Doctors in the second year of foundation training who were working on the general surgery ward told us that they are supervised by a middle-grade doctor, who is on call but not resident, from 9 pm. The doctor in training is responsible for taking new acute referrals and admissions into the ward. However, new and potentially very sick patients may not be seen by a more senior doctor for over 12 hours if the doctor in training does not think their supervisor should see the patient immediately. This was raised as a concern on our visit and the Trust took immediate steps to provide on-site supervision. This issue is now being managed through our enhanced monitoring process.

Case study: High workloads at Hull and East Yorkshire Hospitals NHS Trust

Both doctors in training and their educational and clinical supervisors described the workload in the emergency department as being extremely high, which can affect the level of supervision available to doctors in training. We heard that, in some circumstances, a very sick patient may be seen and discharged by a doctor in the second year of foundation training without being referred to a more senior colleague. This was raised as a concern on our visit and is now being managed through our enhanced monitoring process.
Case study: Issues with rota gaps at Mid Yorkshire Hospitals NHS Trust

We heard that rota gaps can result in doctors in training in obstetrics and gynaecology being on call for both obstetrics and gynaecology. When put in this position, the competing pressures of caring for patients in both areas means they do not feel able to provide a good level of care for gynaecology patients because obstetrics patients are prioritised.

Clinical and educational supervisors also said the rota gaps in this department are an issue. Although we heard that steps were being taken to fill the gaps and develop new job plans, the supervisors acknowledged that this had led to a lack of support for doctors training in gynaecology. Rota gaps, coupled with an intense workload for doctors in training who need to cover both obstetrics and gynaecology, could lead to patient safety issues. We also heard that some acute admissions to the gynaecology unit were not seen by consultants.

This was raised as a concern on our visit and is now being managed through our enhanced monitoring process.

Rotas need to distinguish different doctors’ level of competence

At each of the seven LEPs that we visited, the doctors and staff we met with frequently used the term senior house officer (SHO) and referred to SHO rotas. SHO can refer to doctors in the second year of foundation training, in the first and second years of core training, in general practitioner (GP) training or in junior higher specialty training.

We heard that there is no distinction on SHO rotas between the different stages of training, and it is not clear from the rotas what level of training an individual doctor has had. This can be confusing, not only for doctors in training, but importantly for members of the multidisciplinary team and for patients. This may lead to doctors being asked to work outside the limits of their competence or without appropriate supervision. The continued use of the term SHO is a national problem that we and other organisations are trying to address.
Trainees at some LEPs need adequate time for education

During our visits to LEPs, we heard that educational and clinical supervisors do receive training for their role and that the LEPs manage and monitor their attendance at training events.

All the educational and clinical supervisors we met confirmed they had been trained to undertake their role, but gave a mixture of responses about appraisal. Many said they do not receive a separate appraisal for their training role, and they do not routinely discuss education with their manager as part of their appraisal unless there is a specific reason – such as a particular issue or development need.

Supervisors also reported variable experiences of job planning, and it is clear that this is a challenge for many LEPs and not just within this region. The weekly job plan for a full-time consultant consists of ten programmed activities – 7.5 for direct clinical care and 2.5 for supporting professional activities. HEYH recommends that each supervisor should have an allocated time for training of 0.25 programmed activities per doctor in training. HEYH monitors this through quality visits and gives feedback to the LEPs.

However, we found that the allocated time was not always being recognised in job plans and so implementing HEYH’s recommendation was a challenge. For example, on our visit to Calderdale and Huddersfield NHS Foundation Trust, educational supervisors in paediatrics said they had time in their job plans whereas those in obstetrics and gynaecology did not.

We heard that Barnsley Hospital NHS Trust had recently reduced the allocated time for training from 0.25 to 0.125 programmed activities per doctor in training, which is less than HEYH recommends. Consultants and doctors in training reported that there was very limited time for educational and clinical supervision, and they were not always able to access the programmed activity. It is important that those with an educational role have appropriate time to train.
Quality processes would benefit from a more integrated approach

Each organisation we visited has its own processes for monitoring the quality of medical education and training, including gathering information on the quality of placements and on patient safety concerns. However, it wasn’t always clear how medical schools and HEYH work together to share information.

This is important as doctors in training and medical students will frequently receive training in the same locations and environments. But, if a medical school is concerned about a clinical placement, will they tell HEYH about this concern if doctors are training in the same department? Or tell another medical school if students from another school are also present? HEYH and the medical schools should share information about quality with each other, as well as using information from other professionals within the healthcare setting.

We heard that HEYH and the medical schools are working to develop their sharing of information. There is a gap in terms of undergraduate data as links between HEYH and the medical schools tend to have developed along business lines rather than through quality management initiatives.

We also found that the medical schools and HEYH had variable strengths of relationships with their associated LEPs. We heard some examples of positive working based on specific relationships – eg the associate postgraduate dean at Calderdale and Huddersfield NHS Foundation Trust has good links with both Leeds medical school and HEYH. But, to make sure students and doctors are not put in high-risk situations, these links need to be underpinned by a formal process that supports a minimum level of communication.

We also heard that thresholds for escalating quality concerns – both within organisations (eg up to board level) and to external organisations (eg the Care Quality Commission and the GMC) – are not as clear as they could be. The decision to escalate often relies on subjective judgement, albeit usually an appropriate one. HEYH should set out clear processes for escalation to avoid the risk of inconsistency.

We also learned that the LEPs had an inconsistent approach to representing education and training at board level. Education and training must be considered at board level – ideally it should be a standing agenda item and, if not, there should be clear guidance on exception reporting.
Addressing the changing external landscape

In common with other LETBs, HEYH is facing a number of external challenges, including:

- changes to its own structure
- the impact of changes to funding and the way healthcare is delivered
- difficulty recruiting and retaining doctors in training and consultants, which is compounded by service pressures.

To secure the continuity, quality and safety of education and training, HEYH must continue to develop its strategic relationships with stakeholders. For example, HEYH needs to be involved when LEPs are planning to redesign and reconfigure services – we found that the level of HEYH’s involvement in such changes varied across the seven LEPs we visited. HEYH should also continue to develop links with medical schools to improve the flow of information and data across the transition from medical school to foundation training.

Throughout our visit we heard a great deal about the changes in how healthcare is delivered, and how all LETBs need to adapt to provide the health workforce of the future, to grow and retain their own workforce. HEYH monitors when doctors gain their Certificate of Completion of Training and the local LEPs manage to retain a high proportion of these doctors. However, HEYH might benefit from a formal recruitment strategy based on future workforce requirements.

On the visits to HEYH and the LEPs, we also heard that the challenges with recruiting and retaining doctors in the region is adding to existing tensions between service delivery and training. Training is used to deliver services rather than complementing it. And rota gaps, which vary by specialty and location, are further affecting the quality of training and services.

HEYH needs to continue to take a proactive role in developing a workforce strategy to address the service pressures that can impact or reduce the quality of training.

Medical schools should also have a role in preparing the future workforce. For example, we found that the medical schools are giving students more experience of primary care and community placements. But these placements must be routinely assessed to make sure they are of sufficient quality.

Case study: Developing a primary care academy at Hull York medical school

Hull York medical school was established in 2003 with a specific remit to develop local primary healthcare services. But, despite this, recruiting and retaining GPs in Yorkshire and the Humber remains an ongoing concern.

In collaboration with other stakeholders in the region, the school is establishing a primary care academy to address workforce concerns and to create a centre for research and development. The academy will identify opportunities for students to experience high quality training in a range of multidisciplinary healthcare settings. The school hopes that the facilities offered by the academy will attract high calibre individuals to the region, and also educate and motivate students to consider a career in primary care.
Areas working well

Investments in IT

Throughout our review, we heard that organisations are using technology to improve medical education and training. For example, doctors in paediatrics training use immersion simulation training to help them make the transition from the third to the fourth year of specialty training. Simulation training is also used by doctors returning after a career break and is available to other healthcare professionals. HEYH funds this training and simulation leadership fellows support the training across the region.

HEYH has plans to extend the use of simulation training across obstetrics and gynaecology, but the challenge will be making sure that all the different healthcare professionals have access to sufficient simulation training. Doctors in training who had experienced simulation training with their teams felt that this had helped to foster good working relationships.

HEYH is also developing and implementing a monitoring database – a web-based tool that aims to support the quality team’s work. The database records details of LEPs, visits, progress updates, quality management reports, notable practices and serious untoward incidents. The database was initially piloted across eight LEPs but has now been extended to all LEPs in the region. The monitoring database has the potential to support HEYH’s quality framework at both LEP level (by providing updates) and centrally (by monitoring and reporting).

We also saw examples of medical schools giving smartphones to clinical students and developing mobile apps to aid students’ learning and assessment in the clinical environment, as well as supporting course material and theory.
Case study: Developing mobile apps at Leeds medical school

Medical students told us that IT is well embedded into the course and the school is very responsive to developing this area. Students are very engaged in developing and creating new mobile apps, and the school supports and encourages them to do this – for example, by running student selected components in designing medical education apps.

We were shown an app that students can use to aid their differential diagnosis when admitting patients. We also saw that students can access learning resources remotely and can use their phones to complete workplace-based assessments. The students we spoke to greatly value the range and quality of the apps for helping their learning.

We also heard that this technology is being developed through joint working between students and staff to make sure students have maximum input. Overall, how the school engages students in this area is innovative and very impressive, and it is clear that the school is open and supportive to students driving this agenda.

Involving patients and carers in medical education

At two of the medical schools, we heard how patients and carers are actively and effectively involved in medical education.

Case study: The Patients as Educators Programme at Sheffield medical school

The Patients as Educators Programme is funded by the medical school and involves 750 patients and 100 simulated patients. All patients have to be fully trained, including in patient safety issues and equality and diversity.

The programme includes several initiatives to help students develop their understanding of patient experience, while also enabling them to develop their clinical skills. For example, students get the opportunity to practise history taking and physical examination, to develop procedural and communication skills, and to take part in simulated ward scenarios.

Patients also participate in lectures, giving students first-hand feedback about their personal experiences. The students we met with were highly appreciative of this and found it an invaluable addition to their learning.

This programme is already extended faculty wide to dentistry and is planned to be extended to nursing. It will also be offered to other groups of healthcare professionals in Sheffield and to the medical royal colleges.
Case study: The Patient and Carer Community at Leeds medical school

The Patient and Carer Community is involved in a range of activities at the school, including attending committees and advising on various aspects of the programme, such as student selection, teaching, assessment and feedback.

During our visit, we met with representatives of the group and heard examples of the work they have done. They told us they feel well supported in their roles and receive training for the work they do. The education management team works in partnership with the group and we saw evidence of this on our visit.

We were impressed with how the group has become embedded into the teaching, management and research structure of the medical school, and has become an example of good practice.
Undergraduate education and training

Hull York medical school

Hull York medical school is a joint collaboration between the University of Hull and the University of York, and operates on both campuses. Established in 2003, the school was founded on the premise that it would increase the supply of doctors locally and would thereby improve the quality of healthcare to the region. The faculty is well supported by its two parent universities and is considered a joint entity, as shown by the joint senate. We also found strong staff and student affiliation.

There were 722 students at the time of our visit, and the school has clinical placements in seven LEPs and many GP practices.

We identified an area of good practice, which was the school establishing a primary care academy (see page 9).

We also found an example of the school having made improvements in an area previously identified as an area of weakness, which was making changes to how it teaches pharmacology and prescribing in response to student feedback. The school has introduced a course on pharmacology, prescribing and therapeutics, which is directed specifically at students in years three and four. These changes have also supported the school with introducing a prescribing safety assessment into the fifth year of the programme.
Leeds medical school

Leeds medical school has been teaching medical students since 1831. The school has changed significantly in the past few years, introducing a new curriculum in 2010. The curriculum is continuing to develop in response to feedback from students, LEPs, and university processes, as well as in response to regulatory requirements.

There were 1,501 students at the time of our visit, and the school has clinical placements in 11 LEPs and many GP practices.

We identified several areas of good practice:

- the IDEALS (Innovation, Development, Enterprise, Leadership and Safety) framework – a useful, holistic approach to patient care that encompasses ethics, professionalism, patient safety and the clinical care of patients
- the school’s approach to professionalism, which is underpinned by a mandatory professionalism ceremony for third-year students (see page 4)
- the school’s approach to patient and public involvement in the teaching programme (see page 11)
- the school’s strategic approach to using technology to enhance and support medical education (see page 11).

Sheffield medical school

Sheffield medical school has been teaching medical students since 1828. In the past few years, the school has invested in, and developed, the faculty by appointing leads for innovation and development in clinical teaching at LEP level, and additional administrative staff.

There were 1,341 students at the time of our visit, and the school has clinical placements in ten LEPs and many GP practices.

We identified two areas of good practice:

- the Patients as Educators Programme – a well-developed, supported and valued approach to patient and public involvement (see page 12)
- the school gives students the opportunity to practise interacting with people from a diverse range of social, cultural, and ethnic backgrounds through:
  - focused sessions that are being incorporated throughout the curriculum (eg through role play activities), allowing students to consider their own behaviour and the school to identify and address any potential equality and diversity issues with students
  - sexual health placements, where students see a very diverse group of patients
  - taking a patient’s history via an interpreter to help students develop their communication skills – students and trainers said this experience is extremely beneficial and is highly valued.
Postgraduate education and training

According to our 2014 national training survey, there were 4,704 doctors in training across the region, including 1,238 in foundation training. HEYH works with 21 LEPs, one ambulance trust and almost 300 GP practices.

We identified two areas of good practice. HEYH has:

- invested in simulation training and is using it in an innovative way
- shown a willingness to adopt and develop IT solutions to address challenges.
What’s next for Yorkshire and the Humber?

Following our visits to Hull York, Leeds and Sheffield medical schools and to HEYH, we have set out requirements and recommendations for each organisation in our detailed visit reports (www.gmc-uk.org/regionalreviews). The organisations will update us on their progress towards meeting these requirements and recommendations through scheduled reports. HEYH will monitor updates on the requirements and recommendations from the LEP visits and will report back to us.

We will also look at how to share the areas of good practice with other stakeholders. As part of this, we hosted a regional day in March 2015, to which we invited representatives from all LEPs in Yorkshire and the Humber.

We will continue to support all our stakeholders in Yorkshire and the Humber, and will meet regularly with them to give advice and support. This will make sure that any challenges in meeting the requirements and recommendations of the regional review can be addressed.

We will also take our learning from this review and apply it to the regional reviews of Health Education Kent Surrey and Sussex and Health Education East of England, which are scheduled for 2015.

As a result of the review, three cases were referred to our enhanced monitoring process and we will work with HEYH to make sure that the concerns are addressed.