General Medical Council

# Visit Report on County Durham and Darlington Foundation Trust

This visit is part of our regional review of undergraduate and postgraduate medical education and training in the North East.

Our visits check that organisations are complying with the standards and requirements as set out in Promoting Excellence: Standards for medical education and training. This visit is part of a regional review and uses a risk-based approach. For more information on this approach see http://www.gmc-uk.org/education/13707.asp.

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| **Education provider** | County Durham and Darlington NHS Foundation Trust |
| **Sites visited** | Darlington Memorial Hospital |
| **Programmes** | • Undergraduate (Newcastle Medical School)<br>• Foundation Programme<br>• Core medical training<br>• Obstetrics and Gynaecology<br>• Respiratory Medicine |
| **Date of visit** | 1 November 2018 |
| **Were any serious concerns identified?** | No serious concerns were found on this visit. |

# Findings

The findings below reflect evidence gathered in advance of and during our visit, mapped to our standards.

Please note that not every requirement within Promoting Excellence is addressed. We report on 'exceptions', e.g. where things are working particularly well or where there is a risk that standards may not be met.

### Areas that are working well

We note areas where we have found that not only our standards are met, but they are well embedded in the organisation.

| Number | Theme | Areas that are working well |
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| 1 | 1 (R1.1) | There is a good use of Local Safety Standards for Invasive Procedures (LocSSIPs) as a measure to reduce and prevent serious incidents and near misses. |
| 2 | 1 (R1.3) | There is a culture of support and learning associated with incidents. |
| 3 | 1 (R1.9) | Levels of competency are easily identifiable within obstetrics and gynaecology. |
| 4 | 1 (R1.12) | Rota design is working effectively across the trust. |
| 5 | 1 (R1.13) | Students welcome the opportunity to meet regularly with the Darlington Teaching Team prior to their clinical placement and value the undergraduate induction. |
| 6 | 1 (R1.15) | Doctors in training in respiratory medicine are provided with feedback on their input to management of acute cases. |
| 7 | 2 (R2.1) | There are effective education and clinical governance systems integrated within the trust. |
| 8 | 3 (R3.1) | The portfolio support provided to foundation doctors in training is highly valued by them. |

**Area working well 1: There is a good use of Local Safety Standards for Invasive Procedures (LocSSIPs) as a measure to reduce and prevent serious incidents and near misses.**

1. During our visit, we heard from foundation doctors in training about the recently introduced Local Safety Standards for Invasive Procedures (LocSSIPs). This is a form used for procedures undertaken outside of a theatre environment, designed to ensure that the doctor performing the procedure is competent to do so. The LocSSIPs used at this trust are a modification of the National Safety Standards for Invasive Procedures (NatSSIPs), implemented by NHS England to support the NHS to provide safer care and reduce the number of patient safety incidents related to invasive procedures in which surgical 'Never Events' can occur. We heard that the trust had introduced the use of these LocSSIPs in response to the number of previous patient safety concerns.

2. One foundation doctor in training provided us with an example of previously being asked to perform a chest drain in Accident & Emergency and not feeling confident enough to do so at the time, and assured us that the implementation and encouraged use of the LocSSIPs would now give them the confidence and security to undertake the procedure in the future. The use of the form ensures that the doctor in training is competent and qualified to conduct the procedure, and can evidence the actions needed/the actions taken to ensure the safety of the procedure.

3. The foundation doctors in training that we spoke with told us of the encouragement they received to complete LocSSIPs whenever necessary as a measure to reduce the risks associated with undertaking procedures. They spoke positively of the LocSSIPs, and described how the use of these forms made them feel more confident and enabled safer performance of procedures. We have therefore identified this as an area working well.

**Area working well 2: There is a culture of support and learning associated with incidents.**

4. It is evident that there is a strong culture of support and learning associated with critical incidents within the trust. Throughout the day we heard numerous examples of learning from past incidents, including bespoke sessions in inductions and training sessions.

5. Medical students that we met told us they are aware of critical incidents that had occurred in the previous years, and had been told of adjustments being implemented because of these. They spoke of screensavers on trust computers showing various case studies of these, describing the incident and the steps that the trust had taken in response. The students we met with felt these screensavers were an effective way of sharing learning associated with incidents across the trust, and noted that these often prompt informal discussions around the topic.

6. Educational and clinical supervisors in obstetrics and gynaecology also stated that a third of obstetrics and gynaecology simulation training is based on incidents, demonstrating a way in which the trust is promoting incident associated learning. In addition to this, doctors training in obstetrics and gynaecology told us of a risk meeting that occurs once a week, in which specific incidents are discussed and reflected on.

7. Foundation doctors in training that we met with spoke highly of the support they are given after an incident. An example was provided of a foundation doctor in training that had been involved in a prescribing error. Following the incident, their supervisor met with them and talked through the event to ensure appropriate understanding and learning following it. The supervisor continued to meet with the foundation doctor in training to provide further support. The foundation doctor in training spoke highly of this experience, stating that they felt very supported and believed that the reflection that was encouraged was excellent.

8. We are also pleased to note the numerous meetings and forums that are in place, such as the multi-professional and multi-site risk meetings, the monthly obstetrics and gynaecology ward skills and drills and the learning events for educational management teams of care groups. We heard that doctors in training are encouraged to attend these learning events to present posters designed to promote learning from previous incidents. Undergraduate educators we met with told us that there is a centralised Patient Safety team that is responsible for informing both undergraduate and postgraduate educational teams of incidents in order to support students and doctors in training. They spoke of ongoing work to strengthen the communication channels.

9. It was evident during the visit that the trust highly values and encourages learning from incidents, and provides excellent support for those involved. The trust has several methods for ensuring that learning reaches all levels of students and doctors in training, such as the incorporation of incidents into the simulation training scenarios developed by the trust. We have therefore determined that this is an area working well.

### Area working well 3: **Levels of competency are easily identifiable within obstetrics and gynaecology.**

10. Within obstetrics and gynaecology there is a competency sheet that doctors in training are required to complete when they join the department. This is a self-assessment form that depicts the procedures that they are competent to complete, and asks that the doctor in training is comfortable with what they are being asked to undertake, ensuring that they are not asked to complete a procedure they are not confident in.

11. The educational and clinical supervisors that we spoke with told us that these sheets are consistently maintained and are a pre-requirement to completing any procedure

for all doctors in the department and have been in place for the last five years. They explained that the competency sheet is stored in two places; there is a physical hard copy and a copy stored on a shared drive. This is to ensure that all midwives, nurses and doctors know the competency of doctors in training in the department as their level of competency is easily proven and identified.

**12.** As a consequence of this, doctors training in obstetrics and gynaecology said that they never work beyond their competence, and stated that they were always asked if they felt comfortable performing a procedure beforehand. Moreover, the educational management team stated that all procedures that any new doctor in training performs for the first time in the department are observed.

**13.** The visit team recognised the work that the obstetrics and gynaecology department undertakes to ensure that no doctor in training is working above their level of competence and that these levels are easily identifiable to other professionals working in the department. We therefore identified this as an area working well.

### Area working well 4: **Rota design is working effectively across the trust.**

**14.** During our visit we heard many positive aspects and examples of rota design working effectively across the trust. Overall, we found that the trust is continuously developing the way in which they provide and design rotas, identifying innovative ways to do so.

**15.** The foundation doctors in training who have rotated through the respiratory department told us of the presence of a rota coordinator, who sends out regular emails with updated rotas and requests for swaps. They spoke positively of the use of an e-rota for medicine, which protects simulation learning sessions and teaching sessions. Doctors training in respiratory medicine told us that the use of the e-rota also makes it easier to submit leave requests. They described a 'master' rota that is separate to the e-rota, and explained that the e-rota is filled from the information on the master document. They identified that this means mistakes are possible, therefore an excel spreadsheet is also sent round monthly to ensure both rotas match. They also told us that they find the rota reasonable and flexible when necessary and noted that the rota design is reviewed every year based on the feedback received.

**16.** Educational and clinical supervisors that we met with informed us that they also have an e rota and spoke positively of this. They confirmed that they have reasonable allocated teaching time within their job plans and stated that rotas have been developed to include this based on previous issues and feedback.

**17.** Foundation doctors in training who have rotated through the obstetrics and gynaecology department told us that their rota is designed by a higher trainee, with consultant sign off. They explained that those that coordinate the rota will block shift swaps if the rota is exceeding working hours that week, to ensure compliance with contracts and to avoid fatigue. Furthermore, they stated that teaching sessions were

set in the rota which meant that doctors in training were able to access teaching with more ease and in a far less stressful manner than before. Doctors training in obstetrics and gynaecology explained that this had been changed due to previous issues and feedback.

**18.** Whilst we did hear some reports of variability in rota design within the obstetrics and gynaecology department, mainly due to staff shortages, generally we heard that rota design and delivery worked effectively across the trust. We have therefore identified this as an area working well.

**Area working well 5: Students welcome the opportunity to meet regularly with the Darlington teaching team prior to their clinical placement and value the undergraduate induction.**

**19.** Medical students we met with told us that prior to starting their placement the teaching team from Darlington met with them on a weekly basis for eight weeks, including the tutors that would be responsible for them. During these sessions, the Darlington team discussed what the placement would consist of and answered any questions the students had about the experience.

**20.** The students valued this experience greatly and considered it to be very beneficial to their induction. They felt that meeting with the team prior to the start of their placement made the transition smooth and provided them with the opportunity to resolve any queries they had before they started.

**21.** The medical students that we met with also spoke very highly of their induction experience. They told us that they received an email from the trust prior to their start, containing practical information such as where to go on their first day and where to park. Medical students placed in the obstetrics and gynaecology department told us they also received individualised timetables within this email.

**22.** All medical students we spoke with told us that they received a very thorough induction on their first day. They received an induction pack that contained the syllabus and information from core presentations and policies relating to education and learning as well as information about the hospital. This included fire safety policies, IT policies and raising concern procedures. The wider induction included a site tour, presentations on the general policies and procedures, a talk about raising patient safety and bullying and undermining concerns, and a meeting with their pastoral tutor. They had all met with their clinical supervisor by the end of the week, if not on the first day.

**23.** The medical students we met with said that they found the induction comprehensive and specifically liked how it emphasised pastoral care and support. The individual praise for the meetings with the Darlington teaching team prior to their placement was enthusiastic. It was evident from these meetings that the students value the

undergraduate induction considerably, and we have therefore identified this as an area working well.

**Area working well 6: Doctors in training in respiratory medicine are provided with feedback on their input to management of acute cases.**

**24.** During our visit we identified the consistent provision of feedback to doctors in training in respiratory medicine on their input to management of acute cases. The visit team recognised that this is a challenge across hospitals in the UK and was therefore pleased to hear of positive experiences described by the doctors in training that we spoke with.

**25.** The core medicine and doctors in specialty training in respiratory medicine that we spoke with described the general procedure for overnight acute medical take. They reported that on the post-take ward round the consultants take the opportunity to provide informal feedback on their management of the overnight acute cases. The doctors training in respiratory medicine value this informal feedback greatly, praising the individualised and case related nature. The educational management team informed us of the introduction of an acute intervention team to improve the service on night shifts within the hospital in order to relieve the workload for doctors in training and therefore enhance the training opportunities.

**26.** The doctors training in respiratory medicine spoke highly about this experience and the educational value that it provides them. The visit team recognised the work conducted by the hospital to ensure that the acute medical take has educational value for doctors in training, and we have therefore identified this as an area working well.

**Area working well 7: There are effective educational and clinical governance systems integrated within the trust.**

**27.** The trust provided a clear, comprehensive presentation at the start of our visit, which included multiple organogram's depicting the structure of the trust's governance systems. These explain the systems in place for the flow of information and educational governance, which are transparent and clearly understandable.

**28.** The education management team described a 'live' Quality Improvement Plan (QIP) that ensures efficient reporting of concerns to board level. There are several channels by which concerns can be escalated to the 'live' QIP, including a number of routes that can identify concerns regarding undergraduate and postgraduate medical training. Examples of these routes are a survey for doctors in training that would like to raise concerns anonymously and guardian of safe working tutors and college tutors. If a concern is raised by a doctor in training, it will be escalated through the correct channel. If the concern is deemed appropriate for the QIP, the medical education board then determines if escalating to Health Education England North East (HEE NE) is proportionate. The use of a 'live' QIP allows for 'real time' reporting, and

provides the senior management team with an overview of concerns that are valid and reliable.

**29.** The trust's educational governance structure receives reports from their five care groups, as their service structure is based around these groupings of clinical specialties. These five care groups span the trust and cover all foundation schools, each with a clear structure and dedicated care group tutors. There is a lead education tutor for each care group who oversees the tutors within their group, with a monthly care group forum and a monthly patient safety governance meeting also taking place for all care group tutors to meet with the Director of Medical Education and the Director of Undergraduate Medical Education. There is also an executive clinical leadership group that meets weekly, which all care groups have a representative on.

**30.** In addition to the monthly patient safety governance meetings, the trust has a monthly clinical governance meeting with the aim of exploring Serious Untoward Incident reports (SUIs). It is mandatory to have engagement with doctors in training at these meetings. Reports of doctor in training involvement in incidents are fed into the monthly care group forum, and any major issues can be raised at the weekly executive clinical leadership group meetings. The various patient safety and clinical governance meetings provide a mechanism for relevant concerns to be raised and subsequently escalated to the trust board.

**31.** An example of an issue being identified and escalated through one of these channels is an issue within surgery regarding rota organisation and provision. This escalation resulted in the trust board appointing two surgical rota co-ordinators and the introduction of an acute intervention team to improve night shifts and relieve the workload for doctors in training. It was evident from the visit that there are effective educational and clinical governance systems within the trust; therefore we have identified this as an area working well.

**Area working well 8: The portfolio support provided to foundation doctors in training is highly valued by them.**

**32.** The foundation doctors in training that we met with described robust processes for accessing support within the trust, and spoke positively of the support provided to them for the development of their compulsory e-portfolios. They told us that the portfolio outcomes are discussed in the initial meeting with their educational or clinical supervisor, to ensure that they understand what is required of them from the beginning and to allow them time to discuss any queries that may arise. They also informed us that they receive several presentations throughout the year focusing on the development of the e-portfolio.

**33.** The foundation doctors in training also told us of a dedicated nurse teaching fellow who acts as a lead for support for the e-portfolio. They praised the work of the nurse teaching fellow, and spoke positively of the support that they provide, expressing their gratitude for having mechanisms other than their educational supervisor for e-

portfolio support. They said that the nurse teaching fellow keeps an overview of the progression of each foundation doctor in training, and would provide a detailed, personal plan for support if required. They expressed that they would be very comfortable seeking support from the nurse teaching fellow if they had any queries or worries. The education management team also informed us that the nurse teaching fellow trains the educational supervisors, which ensures consistency in the support they provide.

**34.** It is clear that the foundation doctors in training highly value the e-portfolio support provided by the trust, specifically the support provided by the nurse teaching fellow. It is evident that there is a culture of support throughout the trust, and we have therefore recognised this as an area working well.

## Requirements

We set requirements where we have found that our standards are not being met. Each requirement is:

- targeted
- outlines which part of the standard is not being met
- mapped to evidence gathered during the visit.

We will monitor each organisation's response and will expect evidence that progress is being made.

| Number | Theme | Requirements |
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| | | No Requirements were identified during this visit. |

## Recommendations

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

| Number | Theme | Recommendations |
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| 1 | 1, 3 (R1.8, 3.7) | The trust should ensure that the administration of fifth year medical student placements is consistent, with reliable provision of undergraduate timetables in a timely manner. |

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| 2 | 1 (R1.10) | The trust should make sure that there is an effective system for identifying the different training cohorts. |
| 3 | 1 (R1.13) | The trust should review the induction process to ensure that it is consistent across the trust. |
| 4 | 1 (R1.14) | The trust should review the handover to the labour ward at Darlington Memorial Hospital to ensure structure and educational value. |

**Recommendation 1: The trust should ensure that the administration of fifth year medical student placements is consistent, with reliable provision of undergraduate timetables in a timely manner.**

**40.** Whilst the medical students that we met with spoke positively of their overall experience, they told us that they only receive their timetable a week before its implementation. They informed us that although their university timetable is accessible online for the year, the timetable for their placement is placed on a noticeboard in the department a week in advance. They expressed their frustration with this, stating that it made arranging travel and making plans difficult.

**41.** The medical students also informed us that they were not always expected when they arrived on the wards. They explained that the supervisors were often surprised when they arrived and did not know that they were going to be there that day. The medical students told us that on occasion this makes them feel uncomfortable, as though they are not meant to be there. The timing of the provision of the rotas is deemed to contribute to these instances. However, we heard that if this situation did occur the supervisor would always make arrangements to support the medical student in question, and ensure that they had a valuable experience though not without discomfort.

**42.** The visit team was concerned that the lack of awareness of the medical students would in turn mean a lack of awareness of their educational needs on ward placements and missed learning opportunities. Although it is clear that the education of the medical students is valued and supported by the trust, the administration of the placements is inconsistent. For this reason, we have set a recommendation for the trust to address this.

**Recommendation 2: The trust should make sure that there is an effective system for identifying the different training cohorts.**

**43.** The trust has started to implement a coloured badge and lanyard system for its doctors in training as a means of identifying their different levels of training, and therefore competence, to other staff members. During the visit we did not hear of any incidents of doctors in training having to work beyond their competence, and were reassured that the culture of support within the trust meant that doctors in training were comfortable to refuse a request if they didn't feel ready. However, it was evident from the visit that these measures are not consistent and reliable for identifying a learner's level of competence.

**44.** The core medical trainees that we met with acknowledged that the lanyards do identify different levels of training but were aware that not all doctors in training use this system or are aware of it. They stated that others wouldn't necessarily know their level of competence until a verbal introduction had been made. Despite this lack of clarity, they emphasised that they have not been asked to take consent for anything above their level of competence. Foundation and doctors in specialty training echoed this statement.

**45.** The medical students that we met with stated that the main system for identifying their level of competence is through a verbal introduction. They informed us that there is also an indicator on their identification badge stating 'Medical Student', but recognised that this was hard to identify on sight.

**46.** Whilst it was noted that there is no robust system of identifying of level of competence from sight, the educational and clinical supervisors that we met with told us of a competency sheet in place within the trust. This applies to all levels of doctors in training, and is maintained when they rotate, and has both a physical and electronic copy. This is similar to the obstetrics and gynaecology checklist identified earlier in the report. During the meeting with the educational management team it was noted that there is ongoing work to ensure a consistent and reliable way of identifying levels of competency, with communication from HEE NE emphasising the need for this. We recommend that the trust continues to work on developing an effective system for identifying the different training cohorts.

**Recommendation 3: The trust should review the induction process to ensure that it is consistent across the trust.**

**47.** During the visit we heard of varied experiences of induction within the trust. As noted in area working well five of this report, the medical students that we met with described a comprehensive induction experience that they valued greatly. They welcomed the chance to meet the Darlington teaching team prior to their start and spoke very positively of their experiences.

**48.** However, the foundation doctors in training that we spoke with had varied experiences of induction. They described an effective trust induction that occurred during their shadowing week, including presentations on the core information such as IT training, facilities and introductions to rotas, but gave varied accounts of their departmental inductions. Due to the lack of process of the informal inductions the foundation doctors in training encountered a large variation in departmental induction experiences. Some described formal inductions to their departments; others described informal experiences of discussions that occurred on their first day in the department. We heard an example of a foundation doctor in training missing their induction to the obstetrics and gynaecology department at the University Hospital of North Durham due to being placed on night shift, with no alternative arrangements for induction made. This resulted in the foundation doctor in training feeling out of their depth and having a very negative experience of their placement.

**49.** We also heard an example from some core medical trainees of missing their induction to core medical training. They explained that although they later received the PowerPoint presentations from the induction, they still missed out on some aspects, such as informal discussions that occurred. They were satisfied with their induction experiences, and were confident that the induction prepared them for the job. The doctors training in respiratory medicine echoed this, providing examples of re-organised catch up inductions for those returning from maternity leave. They were content with their induction but stated that specific information about on call shifts was missing and would have been beneficial.

**50.** The educational management team advised us that the trust is moving to a streamlined induction approach, providing access to previous training materials that has been completed by doctors in training in order to avoid duplication. We recognise the work that is being undertaken to improve the induction process within the trust, and encourage them to continue developing this.

**Recommendation 4: The trust should review the handover to the labour ward at Darlington Memorial Hospital to ensure structure and educational value.**

**51.** The doctors training in obstetrics and gynaecology informed us of the handover system within the labour ward at Darlington Memorial Hospital. They explained that previously this was just a verbal handover but now includes paper handover sheets, occurring twice daily. They explained that midwives have a separate handover and that the notes received from this are verbally read out to doctors in training, who then have the option to write this down.

**52.** The doctors in specialty training described a more robust process for the other wards within the obstetrics and gynaecology department, where a handover sheet is entered into the computer system to provide easier and consistent access to the information.

**53.** The lack of structure of the handover in the labour ward left the visit team with concerns regarding its effectiveness and the educational value it provides. We therefore recommend that the trust reviews this process to ensure a clearer structure that provides an effective handover which adds educational value to the experience for doctors in training.

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| **Team leader** | Professor Alastair McLellan |
| **Visitors** | Professor Paul O'Neill<br>Dr. Cleave Gass<br>Dr. Rhona Hughes<br>Ms. Beverley Miller<br>Miss Phillipa Russell |
| **GMC staff** | Christopher Lawlor, Education QA Programme Manager<br>Sophie Whistance, Education Quality Analyst<br>Gareth Lloyd, Education Quality Analyst<br>Samuel Barker, Survey Systems Analyst (observing) |
| **Evidence base** | 1) 2017 – 18 – SAR – CDDFT<br>2) 2017 – 18 – QIP – CDDFT<br>3) Anti-Bullying Charter & Behaviours<br>4) Framework<br>5) Care Group KPIs for Medical Education<br>6) CDDFT HEE NE Visit Reports<br>7) Clinical Effectiveness Group<br>8) Contract MASTER COPY<br>9) Departmental Induction<br>10) Educational Appraisal Template<br>11) Equality, Diversity and Human Rights Policy<br>12) Exception Reporting Policy<br>13) FP Teaching 17-18<br>14) Handbook for Trainees 2017 – 19<br>15) Incident Management Policy<br>16) Incident Reporting Procedure<br>17) Induction Programme<br>18) Job Planning Policy<br>19) Medical Education Strategy<br>20) Medical Education Strategy Group |

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| | 21) Pastoral Student Support<br>22) Raising Concerns Whistleblowing<br>23) SIM Course Book 17-18<br>24) Staff Induction Policy<br>25) Student Handbook 2017-18<br>26) Supervision of Junior Medical Staff Policy<br>27) Supporting Safe Prescribing<br>28) Train the Trainers 2017-18 programme<br>29) Trainee Feedback Sessions<br>30) Training Contract for Shadowing<br>UG Quality Assurance |


## Acknowledgement

We would like to thank County Durham and Darlington NHS Foundation Trust and all those we met with during the visits for their cooperation and willingness to share their learning and experiences.