General Medical Council

Regulating doctors
Ensuring good medical practice

Visit to Aintree University Hospital

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

Review at a glance

About the visit

Visit date	10 October 2013
Site visited	Aintree University Hospital, Aintree University Hospitals NHS Foundation Trust
Programmes reviewed	Five year medical school programme (Liverpool University) Foundation Core medical training General Practice training in secondary care
Areas of exploration	Quality management and quality control; transfer of information; clinical supervision; educational supervision; assessment and feedback; curriculum delivery; workload.
Were any patient safety concerns identified during the visit?	No
Were any significant educational concerns identified?	No
Has further regulatory action been requested	No

via the responses to concerns element of the QIF?	

Summary

1 Aintree University Hospital was visited as part of the GMC regional review of education and training in the north west of England. The review includes undergraduate medical education, and postgraduate training in foundation, core medicine, core surgery, paediatrics, neurosurgery and for general practice placements in secondary care.

2 The GMC's National Training Survey (NTS) highlighted that service pressures and workload are impacting on the quality of educational experience. In addition to levels of overall satisfaction that were below the national average, doctors training in foundation, core medical training and general practice submitted comments relating to workload and potential patient safety issues about their rotations in the cardiology, emergency medicine and general internal medicine departments. Reassuringly these issues have been identified by Health Education North West (HENW) through a quality management visit undertaken by the then Mersey deanery, and the resolution and monitoring of three concerns about workload and one about clinical supervision have been included in scheduled reporting by the dean to the GMC.

3 The local education provider (LEP) is a busy hospital, with a committed and enthusiastic team of educators that are keen to provide a good training experience to students and doctors in training. This is hampered at times by the heavy workload and a lack of protected time in job plans for educational supervision. Quality of training could be improved further by the systematic collection of quality data across the LEP.

Areas of exploration: summary of findings	
Quality management and control	The collection and use of evaluation data across the LEP could be improved. There is not a systematic approach for collecting and reviewing quality data across all departments within the LEP. There are, however, a number of departmental and programmatic initiatives that are working well and could inform the development of LEP quality control processes (see recommendation 2).

Patient safety	There are some good initiatives around patient safety and also a number of potential risks: Outdated terminology is used when referring to grades of doctors in training, which could potentially lead to inappropriate expectations of their competence and the level of clinical supervision required (see requirement 1). Foundation year 1 and year 2 doctors (F1s and F2s) are, on occasions, taking consent without appropriate training and when they do not feel competent to do so (see requirement 2). Processes for reporting clinical incidents are not universally understood by all doctors in training (see recommendation 1). When F1s first take up post they are accompanied during on-calls by a nurse to ensure they understand their responsibilities, where to access services within the LEP and are confident to practice more independently. The Medical Director leads a project for doctors in training to learn from patient safety incidents and act as agents of change to improve service. Following a serious untoward incident a project sponsored by the LEP and delivered by doctors in training has resulted in the development of an online system for assessing skills and interpretation of data.
Clinical supervision	As well as the use of out dated terminology as outlined above, clinical supervision is impacted by workload and understaffing (see recommendation 3).

Educational supervision	There is an enthusiastic and committed team of clinical teachers at the LEP and all doctors in training that we met had a named educational supervisor. There are some excellent initiatives including a weekly meeting of local faculty where doctors in training requiring additional support are monitored, and a training programme director with a remit for supporting non-training grade doctors. There are some challenges for clinical supervisors of doctors training in general practice (GPSTs) who do not have access to the e-portfolio and whose familiarity with the curriculum could be improved (see requirement 3). Not all educational supervisors have time in their job plans for educational supervision (see requirement 4).
Assessment and feedback	Most doctors in training did not report difficulty accessing assessment and feedback. This was more of a challenge for GPSTs completing assessments online. Clinical supervisors of GPSTs are given temporary access to the e-portfolio to complete assessments, this does not allow them to see the results of previous assessments and identify whether improvement is being made or if there are patterns indicating areas of weakness and which therefore require further support (see requirement 3).

Curriculum design and delivery	There is appropriate engagement with Liverpool medical school in curriculum design and delivery and there is a broad range of clinical cases to meet undergraduate and postgraduate curricular requirements. Educational supervisors and the education management team have been engaged by Liverpool Medical School in the review of the undergraduate curriculum. There have only been preliminary discussions so far, but this initial approach from the Head of School was welcomed and staff hope to have a continuing role in the development of the revised curriculum. Students of all years, F1s and F2s recognise the wealth of clinical experience available at the LEP and were able to access enough clinical cases to meet curricular requirements. Year 5 students thought they were being well prepared for practise. F1 doctors who graduated from the school considered the student assistantships in particular had helped to prepare them for practise. There are weekly taught sessions for F1s. The F1s reported being able to attend most sessions and that they could not be called away for clinical reasons. F2s advised us that this was an improvement, as their F1 teaching sessions had not been protected. There are three one-hour taught sessions per week for F2s. This time is not protected but F2s valued the content of the teaching, which they considered to be markedly better than the F1 teaching. It is a curricular requirement that doctors training in core medicine attend at least 12 clinics per year. Doctors in training and their supervisors reported that meeting this requirement is challenging for many. There has been improvement in some departments where clinic attendance has been included in rotas (see recommendation 4).

Workload	It was widely recognised by doctors in training at all levels, their supervisors and the management team that the LEP is extremely busy and workloads are high. The LEP is conscious that the numbers of doctors in training is unlikely to increase so is considering alternative ways of delivering service and relieving pressures on staff. This is important when ensuring doctors in training can access educational opportunities. GPSTs in particular considered the service element of their posts to considerably outweigh the training element.

Areas of improvement

We note improvements where our evidence base highlighted an issue as a concern, but we have confirmed that the situation has improved because of action that the organisation has taken.

Number	Paragraph in *The Trainee Doctor*	Areas of improvement for the LEP
1	TTD 2.2	The recognition through doctors in training evaluation that the acute medical take was not working, and the initiative to address this including the dedicated time of two consultant physicians.

Area of improvement 1: **Acute medical take**

4 During its 2011 annual assessment visit, the then Mersey deanery highlighted challenges with the acute medical take and made a 'mandatory recommendation' that medical takes and lines of responsibility needed to be reviewed. The LEP's progress was monitored during the 2012 annual assessment visit and the recommendation was considered to be achieved however senior trainees working in medicine continued to be concerned over workload, organisation, patient flows and potential patient safety issues. This led to three further 'mandatory recommendations': to review the medical HST rota so training

opportunities are not lost; to review arrangements for GP referrals across medicine and the emergency department and to provide phlebotomy services to support doctors in training.

5 The LEP has responded positively to the 'mandatory recommendations'. Two consultants have been withdrawn from providing clinical service and tasked with reorganising the acute medical take. They engaged a group of doctors in training to help assess where the problems lay and generate potential solutions. Although workload is still high and there remain gaps within the HST rota, there has been a marked improvement. The flow of patients from the GP referrals and the emergency department to medicine is more systematic, the lines of accountability are clearer with a designated lead for the acute medical take during each shift. F2s recognised that the acute take is less busy but highlighted that more middle grade support would be beneficial. They acknowledged that working in blocks with a week off was an improvement and welcomed the additional rest days. This view was supported by CMT doctors and GPSTs who described the rota as one of the best they had worked.

6 Excellent progress has been made and the LEP continues to consider the review and manageability of the acute medical take as high priority.

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 *The Trainee Doctor*	Requirements for the LEP
1	TTD 1.2	Current terminology must be used when referring to the grades of doctors in training and designing rotas to ensure appropriate clinical supervision and expectations of doctors' competence.
2	TTD 1.2, 1.4	Foundation doctors must only take consent if they have been appropriately trained and are competent to do so.
3	TTD 5.2, 5.20	Clinical supervisors of GPSTs must be familiar with the GP curriculum and have access to the GP e-portfolio.

4	TTD 8.4	Ensure that all staff with responsibility for educational and clinical supervision have time allocated for education in their job plans.

Requirement 1: Current terminology must be used when referring to the grades of doctors in training and designing rotas

7 During the visit we met a number of doctors in training, their supervisors and members of the management team who used outdated terminology to refer to doctors in training.

8 Examples of outdated terminology included 'senior house officer' (SHO) and 'senior SHO' when referring to doctors in foundation year 2 (F2), core medicine years 1 to 2 (CMT1-2) and general practice specialty trainees (GPSTs). Doctors of these grades are included in a single 'SHO rota' and treated as a consistent group with the same arrangements for clinical supervision. The appropriate level of clinical supervision and expected competence of an F2 that has just begun a four-month post in a specialty is considerably different from a CMT2.

Requirement 2: Ensure foundation doctors taking consent understand the proposed intervention and are competent to do so

9 We found that some doctors in training at the LEP were taking consent from patients for procedures without having the necessary level of competence or understanding of the procedure to do so. F1 doctors reported taking consent, in geriatrics posts without having training. In addition, F1 doctors in geriatrics were asked to make capacity assessments to determine whether patients were able to give consent without any training. F1 doctors were also taking consent in general medicine posts after only cursory training. Some F1s would refuse to take consent if they did not consider this within their competence, but this was not universal.

10 F2s reported similar issues with consent in urology, being told by senior doctors to take consent even when they did not feel competent to do so or to take consent by proxy with a more senior doctor on the telephone. Foundation educational supervisors recognised that this could be a problem but cited examples of good practice elsewhere in the hospital including in trauma and orthopaedics where consent forms must be countersigned by a consultant, the doctor in training and the patient.

11 Doctors in training should only take consent if they understand the

proposed procedure, potential risks and can advise patients appropriately.

Requirement 3: Clinical supervisor familiarity with the GP curriculum and access to the e-portfolio

12 Clinical supervisors of GPSTs do not have access to the GPST e-portfolio and are not familiar with the GP curriculum. This makes it difficult to ensure GPSTs are meeting curricular requirements, and to make the most of educational opportunities. GPSTs we met considered their posts to be almost entirely service oriented and that learning opportunities tailored to their future careers were missed.

13 We met GPSTs based in the emergency department and within general medical specialties who considered their posts to be almost entirely service driven. They identified a number of potential learning opportunities that would assist them in their future careers as GPs that were not made available to them. These included attendance in outpatient clinics and analysis of GP referrals to the emergency department.

14 The GP clinical supervisors and training programme director acknowledged there is a lack of familiarity with the curriculum and problems accessing the e-portfolio. They valued the contribution GPSTs make to the LEP and are keen to support them to meet their educational needs better.

Requirement 4: Agreed job plans, including allocated time for education

15 The LEP policy is that educational supervisors should have one hour per week set aside for each doctor in training that they supervise. This time should allow for the setting of educational objectives, monitoring progress, recording supervised learning events and providing guidance and advice for doctors in training.

16 This time should be protected and included in their consultant job plan. We heard from educational supervisors, training programme directors and the LEP management team that this has not been universally implemented and not all educational supervisors have time in their job plans for educational supervision.

17 We noted also that the current director of medical education has a very broad remit covering both undergraduate and postgraduate medical education. Although he has support from administrative staff, and

postgraduate training programme directors, this is a considerable workload that regularly requires him to work beyond his allocated five sessions per week.

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 *The Trainee Doctor*	Recommendations for the LEP
1	TTD 1.1	Doctors in training should be provided with guidance and training to report clinical incidents.
2	TTD 2.3	The LEP should introduce systematic collection of quality data including evaluation from doctors in training to support its quality control processes.
3	TTD 1.2	The LEP should make alternative arrangements for clinical supervision of foundation doctors working in medical specialties if workload or understaffing mean clinical supervision is not optimal.
4	TTD 6.10	Aintree should ensure that high workloads in CMT do not prevent doctors meeting their training requirements for attending outpatient clinics.

Recommendation 1: Reporting clinical incidents

18 We found that not all doctors in training understood the processes for reporting clinical incidents. F1s, F2s and doctors training in CMT advised that they were not familiar with the process for formally reporting clinical incidents and would welcome some guidance from the LEP. None had been trained in using the LEP's incident reporting systems.

19 F2s reported that there was a form on the LEP's intranet to report clinical incidents. The form was described as long and complex, and doctors in training we met stated that it did not get information across well. They were also not aware of the DATIX tool, which is the LEP's main system for managing clinical incidents.

20 All groups of doctors in training we met confirmed they would raise concerns and report problems to their consultant supervisors and we did

not hear that any clinical incidents had gone unreported.

21 Ensuring doctors in training are able to use incident reporting systems would reduce the risk of clinical incidents going unreported, and may provide improved educational opportunities for doctors in training.

Recommendation 2: Evaluation by doctors in training

22 There is currently no systematic collection by the LEP of evaluation by all doctors in training about the quality of their training. A number of departmental and programmatic initiatives are in place, which could be rolled out more widely or used to inform the LEP's quality control processes.

23 Evaluation data provided by doctors in training through the GMC survey, the 2011 and 2012 annual assessment visits by the then Mersey deanery and CMT exit interviews identified that the acute medical take was badly organised, onerous and that the rota did not allow adequate rest breaks. Following this evaluation, two consultants were given the task of redesigning the service and the rota that supports it. Although still a busy unit doctors training in core medicine told us there had been a marked improvement, demonstrating that there had been a response to their evaluation (see area of improvement 1).

24 All doctors exiting core medical training are interviewed and their views sought about the quality of training, including educational supervision. This information is used to improve quality of training for future cohorts. Similarly, foundation training programme directors meet all foundation doctors at least once a year to discuss their progress and the quality of training. This allows improvements to be made while doctors are still within the programme as well as improving quality of training for future cohorts.

25 While there are several processes for achieving quality improvements in individual departments or programmes, there is not a systematic process for gathering data across all programmes or departments within the LEP. This means there is a risk that quality management activities take place sporadically and that coverage of all training at the LEP may be incomplete. The LEP should implement a regular and comprehensive system to collect and report evaluation data from doctors in training across the LEP as a whole, so that education and training issues can be identified, monitored and resolved in all departments within the LEP.

Recommendation 3: The LEP should make alternative arrangements for clinical supervision of foundation doctors working in medical specialties if workload or understaffing mean clinical supervision is not optimal.

26 There are a number of unfilled posts in the higher specialty training (HST) medical rota. This can lead to potentially inadequate clinical supervision of F2s working in medicine.

27 This also places a heavy workload on the HST doctor who must cover the emergency department, the acute medical take and medical wards, while also being a member of the medical emergency team that can be called to deal with patient arrests anywhere in the hospital.

28 The LEP should consider using alternative arrangements to provide clinical supervision of foundation doctors working in medicine if workload and understaffing means that the HST is not best placed or able to provide this.

Recommendation 4: Attendance at clinics

29 All doctors training in core medicine must attend 12 clinics per year to meet the requirements of the approved curriculum.

30 We heard from doctors in training and their supervisors that this had been a challenging requirement to meet, often because workload was too high for them to leave the wards.

31 Some departments have now timetabled clinics into rotas. This is not yet uniform practice and we heard that some departments did not understand it was a requirement of the curriculum. Doctors in training and their supervisors highlighted that attending clinics while working at the Walton was particularly challenging.

32 We do recognise that educational supervisors have made a concerted effort to ensure doctors in training meet the curricular requirement, an example was given of one doctor in training who began a post having attended only four clinics that had now had the opportunity to attend 20.

33 We did not hear of any ARCP failures as a result of these challenges and it is important that Aintree should ensure high workloads do not prevent doctors meeting their training requirements for attending outpatient clinics.

Acknowledgement

We would like to thank Aintree University Hospital and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.