General Medical Council

Visit to Bedford Hospital NHS 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	26 October 2015
Site visited	Bedford Hospital
Programmes reviewed	Anaesthetics, General Surgery and Obstetrics and Gynaecology (O&G)
Areas of exploration	Patient safety, induction, rotas, placements and curriculum delivery, training and support for trainers, support for students and trainees, balance between service and delivery and equality and diversity.
Were any patient safety concerns identified during the visit?	Yes
Concern	**1** Foundation Year 2 doctors in trauma and orthopaedic (T&O) and ear, nose and throat (ENT) surgery were found to be working during the night at weekends with off-site clinical supervision. **2** Foundation doctors were sharing their log-in details with locum doctors to allow access to clinical assessments and prescribing, resulting in the foundation doctor signing off prescriptions

	for patients they have not seen.
Action taken	**1** This was raised with the senior management who have now ensured that foundation doctors have access to middle grade doctors from the emergency department during out of hours. We are reassured that the trust have addressed this issue. **2** The trust were made aware of this issue prior to the visit and had raised it as a Datix report due to the risks it held. The medical director fast-tracked the process with the IT team and as of 26th October 2015, all locums receive identifiable temporary log-ins and IT packs. This was followed up with a letter to all medical staff informing them of the IT packs for locums, and that if passwords were previously shared with locums to change them immediately. The trust acted quickly and effectively. We are reassured that the trust have addressed this issue.
Were any significant educational concerns identified?	No
Has further regulatory action been requested via enhanced monitoring?	No

Summary

1 Bedford Hospital NHS Trust (the trust) is an acute district general hospital which provides a range of services to over 270,000 people living predominantly in north and mid Bedfordshire. Services are delivered mainly from one site at Bedford Hospital and are managed and delivered by three clinical divisions: Medicine and Diagnostics, Surgery and Anaesthetics, and Women's and Children's Services.

2 We visited the 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 year five and six students from Cambridge School of Clinical Medicine, foundation doctors from a range of specialties including anaesthetics, general surgery and obstetrics & gynaecology, core surgical trainees, and higher trainees in anaesthetics and obstetrics & gynaecology.

3 In October 2012, Health Education East of England (HEEoE) found that doctors in foundation, core and higher specialty training in paediatrics at Bedford Hospital NHS Trust were experiencing unsafe levels of clinical supervision and having issues with handover and paediatric resuscitation. Paediatrics was therefore raised as a GMC enhanced monitoring item. As a result, second and third years of specialty training in paediatrics were suspended at the trust from August 2013. The GMC joined HEEoE on a follow-up visit in April 2014 to review their progress against the action plan, which was positive. Conditional approval for return of GP trainees was given from August 2014 for 6 months, and foundation trainees returned in December 2014. The GMC and HEEoE decided in October 2015 there was sufficient evidence that the issues in the trust had been resolved and the changes were sustainable. As a result, this case has now been closed.

4 We were impressed with the progress the trust had made. There were areas requiring improvement but the trust were aware of the issues and were making progress to address them. All students we met were very positive about their experience and would recommend the trust to others. Students and trainees on the whole across all specialties and levels reiterated the supportive environment and friendly staff.

Areas of exploration: summary of findings	
Patient Safety	Students were aware of how to use the patient safety reporting tool through the Cambridge MedEd portal and the red button on the home screen. Doctors in training whom we met were informed about patient safety processes at their induction, and felt that they would know who to contact to escalate any patient safety issues with confidence. Supervisors told us that they ensure they are approachable to doctors in training and would provide advice on other ways to raise concerns if doctors in training felt they could not confide in them. Datix reporting is also being used to raise issues regarding patient safety, but the provision of feedback following Datix reports to doctors in training and departments is variable. Foundation doctors in general surgery felt that Datix was being used incorrectly to raise facilities issues which were not related to patient safety. During the visit we noticed that some students wore lanyards which had 'student doctor' printed on them. This may cause confusion for patients who could think medical students are qualified doctors. We were told by the supervisors that the lanyards were provided by the medical school. Throughout the visit, students and doctors in training that we met used the terms 'senior house officer' (SHO) to refer to trainees from foundation year 2 and core medical training and 'registrar' for ST3+ trainees. The terms 'SHO' and 'registrar' are ambiguous because they do not specify the level of training that the doctor is at. See Requirement 5.
Induction	Most doctors in training we spoke to informed us that they had received a trust and departmental induction before starting their post. Many doctors in training thought that the trust induction was too long and consisted of generic information. The education management team are currently streamlining the trust inductions to create a passport system so doctors in training who are up to date with compulsory training will not have to repeat sessions at different inductions.

	The trust is also looking into blended training and mapping sessions across inductions so trainees would not have to attend all classes. The trust has regular meetings with all involved in induction to help improve and share learning. Foundation trainees in both general surgery and anaesthetics mentioned that there were difficulties in receiving inductions when starting in post on a night shift. There were also difficulties in having an opportunity to shadow the night team during the mandatory foundation induction. O&G higher trainees told us that their department would only put trainees who had been at the trust before on nights first, which might be something that other departments could adopt. Anaesthetics trainees told us that at departmental induction there was a good higher trainee or consultant presence. They also mentioned that trainees said that the college tutor was also present on the first two days. Supervisors we spoke to mentioned that they encourage F1s to shadow F2s, which foundation doctors said they found very helpful. O&G supervisors said they get their doctors in training to induct new doctors in training, explain what to expect, give them a tour of the department and introduce them to staff, which O&G trainees we met told us was proving useful.
Rotas	The trust's senior management team is aware of the issues with rota gaps and are making efforts to address this but are facing difficulties. Middle grade doctors in training in medicine currently have the largest rota gaps. Their main difficulties have been recruitment to training posts and the variability in the quality of locum doctors. See Requirement 1 In January 2015, the trust found that the gaps were affecting training so increased locum presence to ensure service delivery would not impact on training. The education management team have tried to ensure that all teaching time is protected, which was confirmed on the whole by trainees we met. Foundation doctors in anaesthetics told us that though their teaching sessions

	are meant to be bleep free, they nevertheless carried bleeps. This was due to issues with cover for them whilst they are attending teaching. They also mentioned some teaching was for both F1s and F2s, leaving the department with no cover at that level. Supervisors we met with told us that they try to ensure that teaching time is protected and bleep free and where there are instances when doctors in training in anaesthetics cannot attend teaching, an alternative session is made available to them. Doctors in training in anaesthetics and their supervisors informed us that alternative staffing arrangements were being looked at to address rota issues, including the potential introduction of physician's assistants and specialist nurses in medicine. This would result in less cover from doctors in training in anaesthetics on the medical rota. All doctors in training in anaesthetics were very positive about the support they receive from the college tutor, and the changes they have implemented. See areas of improvement 1. Higher doctors in training in anaesthetics told us that their rotas were constructed by their trainee representative who would ensure they were available to attend teaching sessions.
Placements and curriculum delivery	Foundation doctors in general surgery and doctors in training in core surgery told us that they have little or no exposure to theatre and clinics. Doctors in training in O&G had very good scanning experience through the scanning trainer, and good access to theatre. The medical students we met told us that they have ample opportunities to attend theatre. Foundation doctors we spoke to across various specialties said that the clinical skills unit is not used as part of their formal teaching. Education supervisors mentioned that the clinical skills labs are available but only for higher trainees. Foundation doctors we spoke to were unaware of the foundation school's presence or what the role of the foundation school was. At the time of the visit, the local faculty groups did not have any foundation doctor representatives so would be unable to gain sufficient

	input on the foundation programme. See Requirements 2 and 4 and Recommendation 1.
Training and support for trainers	All educational supervisors have recently been required by the trust to reapply for their posts. Supervisors told us that this process was well accepted and said that the trust provides good training for the role. All educational supervisors told us that their supervisor role was noted within their job plan which would be reviewed after a month of the start date to ensure that it was going well. Cambridge School of Clinical Medicine are running road shows for trainers to provide information on the new curriculum and the School have been available to provide support to trainers. Trainers have also received an opportunity to provide feedback to the school on the new curriculum. Supervisors told us that they have attended a regional day organised by the HEE local office, which provided information on support systems and changes to assessments for doctors in training. All trainers receive a yearly appraisal. We were told that the college tutor would collate all education supervisors' appraisals into a report for the senior management team.
Support for students and doctors in training, including supportive environment	Students and doctors in training we met told us that the environment was friendly and supportive. Most were also impressed with the strong consultant presence and felt that they would be confident to approach consultants if they had any issues. The education management team at the trust felt that they had very motivated educators which ensured a supportive environment for their doctors in training. Supervisors in anaesthetics and O&G told us those that are in trainer roles are very passionate about training. The trust offers interprofessional teaching with pharmacists and dieticians, and doctors in training in O&G told us that midwives had helped them in gaining

	experience. We heard that supervisors have introduced a journal club created for each specialty where doctors in training are able to share their own work. Doctors in training are also free to attend other specialty journal clubs if they are able to. Doctors in training and students across all specialties told us that there are many opportunities to offer feedback on different elements of their training. Education supervisors receive feedback from their doctors in training which is embedded as part of their routine annual reporting to senior management. Doctors in training in O&G felt that their views were listened to and that the trust management team are open to enacting changes. This view was also held by the educational supervisors. Overall, doctors in training felt they were well supported by their supervisors and were in regular contact with them. Some doctors in training in general surgery said that due to workload, their clinical supervisors are sometimes difficult to contact. All students and the majority of doctors in training that we met would recommend the trust as a place to train. See Good Practice 1, 2 and 3.
Balance between service and delivery	Senior management told us that efforts were being made to protect teaching time. The trust acknowledges that the ongoing inability to sustain the required levels of medical workforce have compromised training provision. Supervisors we met with told us that they try to ensure that teaching time is protected and bleep free. The trust is looking into alternatives to locum doctors, such as physician's assistants and nursing specialists to aid in the Medicine department. Foundation doctors in general surgery felt that there was significant pressure on service to take priority over training.
Equality and Diversity	All groups we spoke to had undergone mandatory online equality and diversity training. However, both doctors in

	training and the education management team were unaware of what is done with the protected characteristics information which is submitted to the workforce department. The education management team told us that equality and diversity data is not collected for educational and clinical supervisors. We were told that reasonable adjustments for doctors in training would be identified through transfer of information forms and be reviewed by the education lead in the relevant department. We heard that the trust has a few doctors in less than full time (LTFT) training and that this arrangement seems to be working well. See Requirement 3.

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 *Tomorrow's Doctors* / *The Trainee Doctor*	Areas of good practice for the LEP
1	TTD6.7	The trust had good systems in place to gather feedback from doctors in training.
2	TTD5.1,TTD6.17	The positive culture of learning in the O&G department.
3	TTD2.3	Local Faculty Groups allow doctors in training to be involved in discussions with specialty groups and feed into the quality of training.

Good practice 1: The trust had good systems in place to gather feedback from doctors in training.

5 Doctors in training and students across specialties told us that there are many opportunities to offer feedback on different elements of their training. Some felt that this may be excessive at times, but have raised this as an issue which is being looked at by the management team. Doctors in training have access to feedback through the 'My Progress' tool that c be accessed through tablets. Educational supervisors also receive feedback from their doctors in training which is embedded as part of their routine annual reporting to senior management. The education management team informed us that following feedback from doctors in training on particular educational supervisors they have removed their educational supervisor role.

6 The doctors in training in O&G felt that their views were listened to and that the trust management team were open to enacting changes. This view was shared by the educational supervisors, who told us about recent changes made to annual leave allocation following feedback from doctors in training.

Good practice 2: The positive culture of learning in the O&G department

7 Doctors in training in O&G that we met told us that the department was very supportive and had lots of training opportunities. They felt that their posts were more training focused rather than service provision and said supervisors were keen to make sure that their training needs were met through assessments. The O&G rota has been designed so that doctors in training work with the same team and consultant, which they find works well and strengthens the team relationships. Doctors in training mentioned that whilst the on-call rota was busy they felt well supported with good supervision, and considered all consultants to be accessible and helpful. We heard that Datix reports are submitted on a team basis and feedback from these reports is given to the whole team.

8 Doctors in training told us that they had very good scanning experience through the scanning trainer and good access to theatre. We heard that midwives encourage doctors in training and help them get experience.

9 Supervisors in O&G told us that experienced doctors in training induct new doctors in training. This induction includes explaining what to expect, giving them a tour of the department and introducing them to staff. The doctors in training in O&G told us this system was proving to be useful. They also mentioned that their handovers are short and formal, but commented that they were effective. We heard that midwives encourage doctors in training and help them get experience. All O&G trainees we met would recommend their job.

Good practice 3: Local Faculty Groups allow doctors in training to be involved in discussions with specialty groups and feed into the quality of training.

9 The trust has created local faculty groups for each specialty which are attended by trainee representatives. This enables trainee representatives to input into the quality management of the training programme. The representatives are also able to feedback any issues to the faculty group from the trainee forum. The management team told us that this was a good way of getting insight into issues from doctors in training. The management team informed us that when the local faculty group discussed confidential items, such as the progress of specific doctors in training, the representatives would be asked to leave the room and would not be provided with the minutes of this part of the meeting.

Area where there has been an 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 *Tomorrow's Doctors* / *The Trainee Doctor*	Area/s where there has/have been an improvement/s
1	TTD6	The recent appointment of the college tutor in anaesthetics has resulted in improvements to the rota, and positive feedback from doctors in training on the changes implemented.

Area of improvement 1: The recent appointment of the college tutor in anaesthetics has seen improvements to the rota, and positive feedback from doctors in training on the changes implemented.

10 Doctors in training in anaesthetics and the education management team have seen improvements within the anaesthetic department following the appointment of the new college tutor. We heard that rotas now have protected teaching time and access to study leave is supported and easier to take. The management team have received positive feedback from most doctors in training on their experience in the department. We heard that the college tutor was very accessible and would aid with any issues in a timely manner. The college tutor is also available for the first two days when posts start, as part of the departmental induction, and to help new doctors in training settle in.

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 *Tomorrow's Doctors* | *The Trainee Doctor*	Requirements for the LEP
1	TTD8.3 TTD6.32	Long term arrangements must be put in place to address rota gaps so as to not affect doctors' learning opportunities and ability to progress through their training while still maintaining service delivery.
2	TTD5.1	There must be adequate provision in rotas to allow time in theatre and clinic for foundation doctors and doctors in training in core surgery, and attendance at clinics for foundation doctors and doctors in training in core medicine to ensure that they are able to meet the requirements of the curriculum.
3	TTD 3.5, 3.6, 3.7	Equality and diversity data must be collected and analysed at recruitment and during training, and action taken in response to analysis of this data must be fed back to doctors in training and supervisors.
4	TTD8.7	Doctors in training must be able to access a clinical skills lab to develop and improve their clinical and practical skills. A strategy must be in place for doctors in training to have access to clinical skills teaching.
5	TTD1.2	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.

Requirement 1: Long term arrangements must be put in place to address rota gaps so as to not affect doctors learning opportunities and ability to progress through their training while still maintaining service delivery.

11 We heard from the trust senior management team, doctors in training and supervisors that there are issues with regards to rota gaps. The management team went on to explain that the 1/14 rota in Medicine is currently 1/8 so this means there are 6 gaps. Efforts are being made to recruit locums but their suitability tends to vary. Some higher trainees have to take on additional shifts. The management team have advised all education supervisors to ensure that training time is protected.

12 Foundation doctors and higher doctors in training in anaesthetics and O&G reported that higher doctors in training have to be moved to other departments due to gaps in the rota. This results in other doctors having to act-up. They would often have to resolve gaps amongst themselves. Foundation doctors in anaesthetics told us that they are encouraged to hand over their bleeps during teaching sessions but that sometimes there was not suitable cover in place while they were attending these sessions. This resulted in them feeling anxious and carrying the bleep for emergencies, however the foundation doctors we met with had not needed to leave a teaching session to attend an emergency.

13 Foundation doctors in general surgery felt that there was significant pressure on service to take priority over training. They also said that they rarely left on time and that the rota gaps were having a significant negative effect on their workload.

14 We heard that the anaesthetics rota is currently being revised by the trainee representative ensures teaching time is protected. Supervisors in anaesthetics told us that when there are gaps in the rota they contact medical staffing for locums to ensure training is protected. The trust is looking into alternatives to locum doctors, such as physician's assistants and nursing specialists to aid in the medicine department.

15 We noted that though efforts are being made to make teaching time protected, there remains a risk that training may be affected in the future if long term arrangements are not put in place. The trust acknowledges that the ongoing inability to sustain the required levels of medical workforce have compromised training provision. The trust must plan for a more sustainable workforce without over-reliance on medical trainees to deliver clinical service.

Requirement 2: There must be adequate provision in rotas to allow theatre time for doctors in training in core surgery and attendance at clinics for doctors in training in core medicine to ensure that they are able to meet the requirements of the curriculum.

16 Foundation doctors in surgery told us that there was little or no exposure to theatre, and that foundation doctors in medicine had difficulty getting access to clinics. Doctors in training in core surgery also said that there were no dedicated lists or clinics for them and told us that they have approached their supervisors to request

this. This differed to what we heard from the students who told us that they have ample opportunities to attend theatre.

17 Doctors in training must be able to gain sufficient practical experience by means of clinics and theatre time within their respective programmes to support acquisition of knowledge, skills and behaviours and demonstration of developing competency as set out in the approved curriculum.

Requirement 3: Equality and diversity data must be collected and analysed at recruitment and during training and action taken in response to analysis of this data must be fed back to doctors in training and supervisors.

18 All groups we met had undergone mandatory online equality and diversity training. However, both doctors in training and the education management team were unaware of what is done with the protected characteristics information submitted to the workforce department. Equality and diversity data must be collected and analysed during training and the outcome of the analysis made available to doctors in training and supervisors.

Requirement 4: Doctors in training must to be able to access clinical skills lab to develop and improve their clinical and practical skills. A strategy must be in place for doctors in training to have access to clinical skills teaching.

19 Foundation doctors that we met across various specialties told us that the clinical skills unit was not used as part of their formal teaching. We were told by education supervisors that the clinical skills labs were available, but only for higher trainees.

20 Foundation doctors must have opportunities to access to clinical labs to improve their practical and clinical skills, and be supported by teachers, before using these skills in clinical situations. Doctors in training at all levels must also be enabled to develop and improve their clinical and practical skills, through technology enhanced learning opportunities such as clinical skills laboratories. The trust must improve their strategy for doctors in training to access clinical skills teaching.

Requirement 5: 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.

21 Throughout the visit, students and doctors in training that we met used the term 'senior house officer' (SHO) to refer to doctors in training from foundation year 2 and core medical training years and 'registrar' for ST3+ trainees. This was particularly common amongst foundation doctors when describing their escalation procedures, as they had been told to escalate any concerns to the 'SHO' on their team.

22 The term 'SHO' and 'registrar' provides ambiguity for doctors in training as it does not specify the level of the individual doctor. This poses a risk that other staff members may not be aware of the level of experience of the doctors on the rota, and may as a result ask such doctors to work outside the limits of their competence or without appropriate supervision.

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 *Tomorrow's Doctors*/ *The Trainee Doctor*	Recommendations for the LEP
1	TTD5.2, TTD7.1	The management of the Foundation programme needs strengthening to ensure that it is able to deliver the curriculum.

Recommendation 1: The management of the Foundation programme should be strengthened to ensure that it is able to deliver the curriculum.

23 Foundation doctors that we spoke to were unaware of the foundation school's presence or what the role of the foundation school was. When we asked the education management team how the foundation programme was managed we were told through faculty groups. At the time these faculty groups did not have any foundation doctor representatives so would be unable to gain sufficient input on the foundation programme. In order for the foundation programme to deliver the curriculum at the Trust the management of this should be strengthened.

24 The trust working with the Foundation Schools should ensure that there is an appropriate local foundation management team who have the authority and presence in the local faculty groups to ensure that the foundation curriculum can be delivered.

Acknowledgement

We would like to thank Bedford Hospital NHS Trust and all the people we met during the visits for their cooperation and willingness to share their learning and experiences