General Medical Council

Visit to Frimley Health NHS Foundation Trust

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 dates	9 October 2014
Site visited	Wexham Park Hospital, Frimley Health NHS Foundation Trust
Programmes reviewed	Foundation, core medical training, obstetrics and gynaecology, respiratory medicine, general practice in secondary care (GPST).
Areas of exploration identified before the visit	Patient safety, clinical supervision, quality management and quality control, induction, support for trainers, job planning, transfer of information, educational support and learning opportunities, undermining.
Were any patient safety concerns identified during the visit?	No
Were any significant educational concerns identified?	No
Has further regulatory action been requested via enhanced monitoring?	No

Summary

1 Wexham Park Hospital was visited as part of the General Medical Council (GMC) regional review of education and training in Thames Valley. The review includes undergraduate medical education and postgraduate training. Wexham Park Hospital provides undergraduate teaching for Southampton and Imperial medical schools, as they are based outside Thames Valley we did not consider the provision of undergraduate education on this visit. Instead we focussed on postgraduate training in foundation, core medicine, respiratory medicine, obstetrics and gynaecology and general practice placements in secondary care.

2 Formerly part of Heatherwood and Wexham Park Hospitals NHS Foundation Trust, on 1 October 2014, this trust was acquired by Frimley Park Hospital NHS Foundation Trust, to form a new trust; Frimley Health NHS Foundation Trust. There is a history of difficulties, in both the delivery of services and postgraduate training. The former trust had been placed under special measures following an inspection by the Care Quality Commission in February 2014, but we were informed that this was lifted following the acquisition. We met the senior management from the former trust, as well as the medical director and director of education from Frimley Health.

3 We arrived during what is undoubtedly a period of significant change for Wexham Park Hospital. While this has no doubt resulted in a degree of uncertainty, there was a clear commitment from the staff to recognise the opportunities this acquisition presents. Frimley Park Hospital is located within Health Education Kent, Surrey and Sussex. It is not yet known what changes, if any, will be made with regard to the responsibilities of the local education and training boards.

4 Prior to the visit there was one open patient and education concern in obstetrics and gynaecology under enhanced monitoring by the GMC. Although the educational concern is only partially resolved there has been considerable progress made regarding patient safety.

5 We also heard concerns regarding the safety of the Snowdrop Unit, which is used as an escalation ward when inpatient numbers extend beyond permanent bed capacity. This was raised by the Care Quality Commission during its visit on 12 and 13 February 2014. We referred our concerns to the CQC and we will monitor any actions taken to resolve the issues.

6 Overall, most of the doctors in training that we met considered the training experience they receive is good, although a significant proportion , especially in foundation did not always feel well supported and supervised clinically. Although just over half of the foundation doctors interviewed would recommend their post for training, the vast majority we met would not recommend a friend or family to be treated there.

7 Wexham Park Hospital demonstrated a commitment to education and training, and there was openness about the challenges it faces. Nonetheless, there must be a focus to address the service pressures and patient safety concerns to ensure there is a safe environment for both patients and doctors in training. Wexham Park Hospital also recognises this need and we heard about the very successful 'Spring to Green' initiative held in July 2014. This involved a special focus from clinicians for a two week period to support patient flow and increase clinical engagement throughout the trust. The project resulted in an improvement in patient flow and bed availability; and highlighted the staffing resources required to manage workloads. As a result additional staff members have been appointed to work in radiology and occupational therapy.

Areas of exploration: summary of findings. **This section identifies our findings in areas we agreed to explore before the visit.**	
Patient safety	Two potential patient safety issues were raised with us, both of which are known to the organisation and have been highlighted in previous Care Quality Commission reports. These relate to the use of the Snowdrop Unit at times of service pressure, and also the processes of admission from the emergency department to the acute medical unit. We will continue to monitor progress in addressing these concerns and ask the LEP to share with us any updates it provides to the Care Quality Commission on these issues.
Clinical supervision	Clinical supervision was thought to be lacking in some departments, with GPSTs and foundation doctors in particular highlighting a lack of senior support. The foundation doctors do not always feel supported, particularly when working out of hours and at weekends and can find the lack of support stressful. They identified that this would be improved by strengthening out of hours support. The experience of support for doctors training in paediatric posts and respiratory medicine was much more positive. We heard they were well supervised and supported. See recommendation 4.

Quality management and control	Following the publication of the GMC's national training survey, the director of medical education analyses the results and produces an individual report for each department. The medical director reports to the trust board about the survey results The national training survey results can also prompt internal or external reviews to investigate particular themes and issues arising. The 2013 national training survey found negative outliers in respiratory medicine at the hospital for overall satisfaction, induction and study leave, so the trust was asked to investigate. An external royal college specialty adviser reviewed the respiratory department which helped inform the action plan to address the issues. Further negative outliers were found in the 2014 national training survey. The Health Education Thames Valley Quality Management Committee carried out the School of Medicine Autumn Review in October 2014 and a further meeting is scheduled for May 2015. We heard generally positive comments from doctors in training and supervisors that we met in respiratory medicine; however, as we met with a relatively small number, we will continue to monitor progress in light of the previous survey results. We expect the ongoing work will address the issues and will receive a further update on progress in the October 2015 Dean's Report. Most of those we met were familiar with the incident reporting system. Many of the doctors in training had used the electronic incident reporting software system, but few had received any feedback on this. See recommendation 1.
Educational support and learning opportunities	Standards for this aspect of delivery are being met. The majority of the doctors in training that we met consider they get a good level of educational experience and more than half of the foundation doctors interviewed said they would recommend their post to a colleague. We heard that the consultants are in the main very approachable and supportive. The paediatric department was highlighted as particularly strong, with the foundation doctors and

	GPSTs confirming their experience in this department is of high quality. The support provided by the higher specialty doctors and consultants was said to be excellent. The consultants in respiratory medicine were also said to be approachable and motivated to teach. The doctors in training in this department said they were able to obtain advice as needed. They also highlighted the opportunity to discuss and learn from cases in outpatients as being very good. Standards are being met in the aspects of educational support and learning opportunities that we explored on this visit.
Induction	The quality of local departmental induction was said to be mixed, with improvements noted since August 2013 by doctors training in obstetrics and gynaecology and medicine. Foundation doctors consider they would benefit from further emphasis on the management of emergencies during their first few weeks. Much of the generic trust induction has this year been moved from classroom based to online e-learning modules. The doctors in training raised some concerns about access to and time required to complete the new electronic element of the induction. See recommendation 2.
Support for trainers	All clinical supervisors complete training in clinical supervision and or educational supervision, run by Health Education Thames Valley. Training in educational supervision is also available. The training programme directors meet with the clinical supervisors for GPSTs to inform them about the curriculum. The trainers are content with the level and accessibility of the training available to them locally and through Health Education Thames Valley. Standards are being met in the aspects of educational support for trainers that we explored on

	this visit.
Job planning	The time allocated for education in the consultants' job plans appeared to vary between departments and individuals. We heard that the consultant job plans in obstetrics and gynaecology have not been reviewed since 2012 but we heard there are plans to address this soon. Consultants in obstetrics and gynaecology said they have 0.25 supporting professional activities; that is an hour per week, per doctor in training they supervise. We heard that consultants in respiratory medicine also have 0.25 supporting professional activities per doctor in training, and this is capped at 0.5 supporting professional activities. The clinical supervisors for foundation doctors reported differing supporting professional activities allocations, not specifically written down in many of the job plans. They were unclear as to whether there is a standard amount trust wide. See requirement 4.
Transfer of information	For doctors moving from a different local education and training board into Thames Valley, the transfer of information does not work as well as it could, which can lead to delays in providing additional support to those who require it. This is can sometimes be a problem for doctors in training who move between local education and training boards between foundation year one and foundation year two. We heard that within Health Education Thames Valley the transfer of information about doctors in training had improved. Standards are being met in the aspects of transfer of information that we explored on this visit.
Undermining	The obstetrics and gynaecology department has been under GMC enhanced monitoring since August 2013, as there had been several serious untoward incidents. Linked to the concerns, were reported issues of undermining of doctors in training by allied healthcare professionals and consultants within the

	department. We heard that Wexham Park Hospital's undermining policy had recently been revised, with input from an external expert, and was due for publication during October 2014. We were informed that Health Education Thames Valley had funded the college tutors to attend a training course at Southampton called 'Stop it' aimed at preventing bullying and undermining. At the time of our visit it was planning to pilot similar training locally which would be rolled out across the trust. The director of medical education holds regular 'coffee and cake' meetings with the doctors training in obstetrics and gynaecology, at which they can raise any issues. We heard reports of some continuing issues of undermining of doctors in training by midwives in the department. Standards are being met in the aspects undermining that we explored on this visit.

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 *The Trainee Doctor*	Area where there has been an improvement at the local education provider
1	TTD 2.3, 6.10-6.11	The job planning and rota arrangements for ST5 and ST6 doctors training in obstetrics and gynaecology have been improved to ensure appropriate supervision and educational opportunities.

Improvement 1: The job planning and rota arrangements for ST5 and ST6 doctors training in obstetrics and gynaecology have been improved

8 As part of our enhanced monitoring processes, we were aware of previous problems identified in the rota design and supervision arrangements for doctors training in the obstetrics and gynaecology department. A previous visit with Heath Education Thames Valley highlighted that the rota arrangements did not enable the doctors in training to meet all of their training requirements. Furthermore they did not consistently have the opportunity to influence the rota, and, on occasion could be working without the support of a ST3-4 doctor. We heard that there has since been a successful review of the senior specialty trainee rota in this department, based on individual job planning. The doctors in training were engaged in the development of the new rota design.

9 The ST5 and ST6 doctors in training said they are satisfied with the new arrangements; and that it is helpful to have fixed theatre sessions which ensure they have access to learning opportunities. We heard examples of ST5 doctors' requests for additional sessions to meet their educational needs being accommodated. Wexham Park Hospital should look at options for expanding this to the other doctors in training in obstetrics and gynaecology. See also requirement 3.

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 local education provider
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 2.1	The monitoring of rota hours must be consistent across departments to ensure that doctors in training are not working more than their contracted hours.
3	TTD 6.10	Working patterns and workload in obstetrics and gynaecology must add educational value and enable doctors in training to meet the requirements of their curriculum.

4	TTD 8.4	Clinical and educational supervisors in all departments must have an adequate allocation of time in their job plans for training.

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

10 Throughout our visit, the doctors in training and their supervisors from different programmes and specialties repeatedly used out of date terminology to refer to different training grades. This included frequent use of the term 'senior house officer' (SHO) to refer to doctors in training from foundation year 2, core medical training years 1 and 2, obstetrics and gynaecology in years 1 and 2, and GPSTs.

11 Furthermore, we heard about 'SHO' rotas in some departments, including obstetrics and gynaecology. This rota includes F2 doctors, GPST years 1-2 and specialty trainee years 1-2 (ST1-ST2). The rota does not indicate the grades of the individual doctors in training. The expected level of competence of these doctors varies significantly from an F2 who may have only been in post for a few weeks to a specialty doctor in training with significant experience. The single rota does not ensure that these doctors will receive an appropriate level of supervision. Furthermore, 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. The other staff will also not have an understanding of the career aspirations to support the doctors in training. See also requirement 3.

Requirement 2: The monitoring of rota hours must ensure that doctors in training are not working more than their contracted hours

12 The GPSTs working in obstetrics and gynaecology told us they frequently have to stay beyond their rota hours in order to complete the handover of patients. The clinical supervisors for foundation and GPSTs told us that handover is built into the rota for the labour ward. There is also an expectation that when attending theatre, the GPSTs arrive at 7.30am, rather than the later official start time of 9.00am. The foundation doctors and specialty doctors training in obstetrics and gynaecology also reported the same expectations about early starts and late finishes not being factored into their rota. See also requirement 3.

13 The GPSTs working in obstetrics and gynaecology report keeping a log of their working hours to inform whether or not they are compliant with working time regulations. The supervisors in obstetrics and gynaecology confirmed that human resources do monitor working hours but they do not receive the outcome from this. We heard from the doctors in training that last year the rota was found to be not compliant but the supervisors were unsure and would find it helpful to know the outcome of the working hours monitoring exercises.

14 Doctors training in respiratory medicine report finishing around an hour after the rota hours although sometimes they are able to finish on time. The foundation doctors working in respiratory medicine also reported working beyond the rota hours. Foundation doctors working in general surgery reported frequently working beyond the official rota hours. We also heard reports of early starts for pre-operative assessments in general surgery.

15 The senior management team told us they do not automatically receive the outcome of the working hours monitoring exercises. It is clear that doctors in training are frequently expected to work outside of the official rota hours. The results of working hours monitoring exercises must be shared with the supervisors and senior management teams and these must take into account the extra hours worked that are not factored into the rotas.

Requirement 3: Working patterns and workload in obstetrics and gynaecology must add educational value and enable doctors in training to meet the requirements of their curriculum

16 Doctors training in obstetrics and gynaecology told us they frequently work beyond their rota hours. Antenatal clinics appear to be a particular problem, with the doctors in training reporting frequent overbooking of patients by around 50% and clinics running one and a half hours late. The training opportunities are adversely affected by the overbooking, as doctors in training only have a very short time available to speak to consultants. We heard that while senior support is available, they are not always able to speak to a consultant and may wait up to 15 minutes for advice. There are no opportunities to complete Mini-Clinical Evaluation Exercises (mini-CEX*).

17 We heard that some of the doctors training in obstetrics and gynaecology had completed online critical incident reports regarding the overbooking of clinics, though not all had received feedback on this at the time of our visit and these had not effected changes to the overbooking of clinics.

18 The doctors in training reported that there have been improvements in the last year and progress since the enhanced monitoring visit in April 2014 was evident. There is still more to be done and the working patterns for those on the first on-call rota are not as good as they could be. We heard that the rota designs meant that the GPSTs working in obstetrics and gynaecology can see more elective caesarean sections than the specialty doctors training in obstetrics and gynaecology. The doctors in training would welcome the opportunity to contribute to the rota design in obstetrics and

* The Mini-Clinical Evaluation Exercise is a tool that assesses a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. It can be used at any time and in any setting when there is a trainee and patient interaction.

gynaecology to ensure that each group (GPSTs, foundation and all the specialty doctors in training) can access educational opportunities appropriate to their curriculum and learning needs.

19 Doctors in training told us the local requirements for the number of cervical speculum examinations to be supervised and signed off before independent practice is allowed, is excessive. This was a problem during the enhanced monitoring visit in April 2014 and it continues. We understood this policy had been rescinded but it is unclear whether it remains in place or the change has not been communicated to doctors in training and their supervisors. We were also informed that these doctors are frequently bypassed by the midwives requiring advice from a doctor who will instead go straight to a consultant.

Requirement 4: Clinical and educational supervisors in all departments must have an adequate allocation of time in their job plans for training

20 The time allocated for education in the consultants' job plans varies between departments and individuals. We heard that the consultant job plans in obstetrics and gynaecology have not been reviewed for a couple of years but there are plans to address this soon.

21 Consultants in obstetrics and gynaecology have 0.25 supporting professional activities per doctor in training. The clinical supervisors for foundation doctors reported differing allocations, from 1.5 to 2.5 supporting professional activities in total. They were unclear as to whether there is a standard allocation. We heard that consultants in respiratory medicine also have 0.25 per doctor in training, and this is capped at 0.5.

22 The clinical supervisors in respiratory medicine said they generally have enough time for education, the only problem being if there are particular difficulties with a doctor in training it may require additional time to resolve this.

23 All educational and clinical supervisors must have adequate time for training identified in their job plans. Current arrangements must be reviewed to ensure that clinical and educational supervisors in all departments have an adequate allocation in their job plan.

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*	Recommendations for the local education

	Doctor	**provider**
1	TTD 2.2	Feedback on incidents and serious incidents should be provided to all doctors in training who either report or are involved in an incident to ensure the educational opportunities afforded by quality and risk management processes are being maximised.
2	TTD 6.1	The new online induction and training materials should be improved to ensure doctors in training do not face technical difficulties when completing the modules and can learn about workplace policies in a timely manner.
3	TTD 6.1	The content of the 'Bridging the Gap' training course for foundation doctors should be reviewed to ensure it is meeting their training needs.
4	TTD 1.22	Alternative arrangements should be made for clinical supervision of foundation doctors and GPSTs if workload and understaffing mean clinical supervision is not optimal.
5	TTD 6.7	The foundation doctors would benefit from improved support for the foundation forum so that it can provide an effective means to improve the training experience.

Recommendation 1: Feedback on incidents and serious incidents should be provided to all doctors in training who either report or are involved in an incident

24 During the visit we heard that the director of medical education is informed of all reported incidents involving a doctor in training. Incidents are reported through clinical governance and we were informed by the education team that doctors in training are asked to include reports in their e-portfolios. The director of medical education reports to Health Education Thames Valley on a quarterly basis. There is no automatic process for ensuring that the doctor in training involved with, or who reported the incident, is informed of the outcome of the investigation. The senior management team acknowledged that this is a weakness in the current arrangements.

25 The doctors in training that we met during the visit were aware of how to report an incident online and many had done so. The majority had not received any feedback on the incidents they had reported so far. This included foundation doctors, doctors

training in respiratory medicine, GPSTs and doctors training in obstetrics and gynaecology.

26 In some departments there are opportunities for the doctors in training to learn from incidents. For example, in obstetrics and gynaecology there are incident review group meetings and a newsletter which includes anonymised details of incident reviews. In respiratory medicine, we heard from the clinical supervisors that closing the loop and feeding back to doctors in training could be improved. Incidents are discussed at clinical risk meetings, to which doctors in training are invited, although there is not wide attendance.

27 Reporting and feedback mechanisms and responsibilities are set out in the Heatherwood and Wexham Park 'Incident and Serious Incident Reporting Policy'. This includes the incident handler being responsible for feeding back to all staff the actions taken. These mechanisms are not being implemented consistently at present.

Recommendation 2: The new online induction and training materials should be improved

28 We heard that the LEP has introduced new online induction and training materials for doctors in training. The senior management advised that the online induction was not popular with the doctors in training but that it did reduce the time spent undertaking classroom based training by enabling them to complete the modules in their own time.

29 The foundation doctors we met expressed their frustration with the system, not least the technical difficulties they had experienced when attempting to complete the modules. We heard that in some cases the foundation doctors had not received the required passwords to log in. Some foundation doctors had attempted to complete the online induction outside of the hospital but it had not registered on the system so they were required to repeat it, staying late at work over several evenings.

30 We heard the online induction takes around eight to 10 hours to complete and the doctors in training were uncertain as to the usefulness of the content and the impact on learning. Some of the foundation doctors told us they had already completed some of the content elsewhere and wondered whether it may be possible to be exempt from repeating some modules if evidence can be provided of previous completion.

Recommendation 3: The content of the 'Bridging the Gap' training course for foundation doctors should be reviewed

31 The education management team developed the 'Bridging the Gap' training course, with support from the postgraduate dean and Health Education Thames Valley. We heard from the senior management team that the training was intended to support

the foundation doctors in making the transition from foundation year 1 to foundation year 2. The one day course includes scenario based training in groups, including working with critically ill patients and breaking bad news. Wexham Park Hospital is proud of the training and we heard that evaluation has been positive.

32 The clinical supervisors for foundation doctors believe the training to be well received and useful in addressing some of the softer skills required of foundation year 2 doctors.

33 Some of the foundation year 2 doctors we met were less certain about the value of the training. They told us much of the content was not relevant to them and would be more valuable to the foundation year 1 doctors. For example, they told us they already knew how to write a discharge letter and are familiar with the services provided by other departments such as physiotherapy and occupational therapy. The current cohort had completed evaluation of the training but had not heard how this might impact future delivery of bridging the gap at the time of our visit.

34 Wexham Park Hospital should review the information from the training evaluation and consider whether either the timing or the content can be adjusted to ensure that the benefits to foundation doctors are optimised.

Recommendation 4: Alternative arrangements should be made for clinical supervision of foundation doctors and GPSTs if workload and understaffing mean clinical supervision is not optimal

35 The foundation doctors working in medicine said that senior support is not always available during nights and weekends. The foundation doctors are kept busy and gain a lot of experience, but said they would benefit from additional senior support. They told us it can be difficult to get in touch with a more senior doctor at times, especially at night. This could impact upon their learning and potentially patient safety. Those working in acute medicine find the senior cover to be variable and they are aware that the consultants and higher specialty doctors in training are themselves stretched by the workload so are not always readily available to offer support.

36 GPSTs working in obstetrics and gynaecology noted some issues with senior support in two wards, but not across the department as a whole. We heard that they are able to contact the consultant for support if needed and we heard of an instance when the consultant came in immediately to help during out of hours. They also noted problems at night in general surgery and trauma and orthopaedic surgery when there is a reliance on locum doctors to fill rotas.

37 We also heard of a reliance on locum doctors in other departments, especially in medicine. We heard from foundation doctors that the quality of the locum doctors is variable, while some are excellent, others lack in experience and knowledge of the

NHS systems and also at times a locum may fail to turn up for a shift. They noted ongoing issues with locum access to the computer systems they require, for example to write up patient medical record notes.

38 Senior support does work well in some departments. The foundation doctors training in cardiology, paediatrics, the neonatal unit and respiratory medicine were content with the support they receive from the higher specialty doctors in training and consultants. We were also told by foundation doctors that recent improvements had been made to the staffing of the general surgery department at weekends, with additional doctors now in place.

Recommendation 5: The foundation doctors would benefit from improved support for the foundation forum so that it can provide an effective means to improve the training experience

39 During the visit to Wexham Park Hospital, it was clear there was little awareness of the foundation forum among the foundation doctors. Many were not aware that they had representatives and some others had little awareness of their role and function.

40 During the visit to Health Education Thames Valley, we had the opportunity to meet with the foundation representatives from the hospital. We were impressed by the representatives' enthusiasm and commitment to their role, but were disappointed to hear that support for the forum from the hospital has been limited, and that establishing positive engagement with the foundation training programme directors had been difficult.

41 The foundation forum, if properly set up and supported, could provide an excellent opportunity to make improvements to training experience, as well as a means for the trust to hear about any concerns there may be about patient safety. The work of foundation doctors, especially out of hours, puts them in a unique position to identify and raise concerns about patient safety. The trust should look at implementing an effective mechanism for the forum to share ideas and concerns with the senior management. This would potentially enable good practice to be shared more widely and would support the hospital in addressing some of the complex and long standing issues they face.

42 The trust should consider other measures that could be put in place to support and strengthen the forum. For example, at the subsequent visit to Stoke Mandeville Hospital, we heard that the representatives are supported to complete a management and leadership programme. At Oxford University Hospitals, we heard that there are regular meetings of the local foundation forum, and good levels of engagement with the education management team, ensuring that the forum provides an effective means for foundation doctors to raise issues about their training.

Acknowledgement

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