General Medical Council

Visit to Hull & East Yorkshire Hospitals NHS Trust

This visit is part of a regional review and uses a risk-based approach. For more information on this approach please see the General Medical Council website.

Review at a glance

About the visit

Visit dates	Tuesday 14 October 2014
Site(s) visited	Hull Royal Infirmary
Programmes reviewed	Undergraduate Hull York Medical School, foundation, obstetrics and gynaecology and emergency medicine
Areas of exploration identified before the visit	Student assistantships & preparedness, transitions and transfer of information, induction, placements and curriculum delivery, assessment & feedback, supervision, handover, patient safety, doctors in difficulty and fitness to practise, training for trainers, equality and diversity, bullying and undermining, quality control processes
Were any patient safety concerns identified during the visit?	Yes – see requirements 1 & 2 below
Were any significant educational concerns identified?	As a result of the above issues, foundation doctors reported that the delivery of education in the emergency medicine department was extremely limited.

Has further regulatory action been requested via enhanced monitoring?	The concerns have been referred to the GMC Enhanced Monitoring Process. We will be working with the LETB to monitor improvements

Summary

1 We visited Hull and East Yorkshire Hospitals NHS Trust as part of our regional review of undergraduate and postgraduate medical education and training in Yorkshire and the Humber. Established in 1999, the Trust operates from two main sites - Hull Royal Infirmary and Castle Hill Hospital. In recent months, there have been a number of changes in senior management (both clinical and academic) within the Trust and at the time of the visit a new Chief Executive had only recently taken up post.

2 During the visit we met with foundation doctors years one and two, and doctors in training in emergency medicine and obstetrics and gynaecology. We also met with medical students years three, four and five from Hull York Medical School.

3 The GMC evidence summary identified this Trust as being of interest due to an increase in the number of below average results in the 2014 National Training Survey (NTS). This indicated potential risks to the quality of education and training in foundation surgery, emergency medicine and obstetrics and gynaecology. The Trust was visited by the Care Quality Commission earlier in the year, and our visit coincided with a visit from the Trust Development Authority.

4 As with many healthcare providers nationally, one of the most pressing issues currently facing the Trust is the recruitment and retention of staff and we heard of a number of initiatives that are being considered to address this. However, we also heard examples from the doctors in training we met of how staff shortages and the requirement to provide service delivery are impacting negatively on education and training. At Hull Royal Infirmary, a new emergency department has recently been built which, it is hoped, will address some of the limitations seen in the current acute care pathway however, we also heard of consultant staff vacancies within the department. Despite these challenges, the profile of education and training remains high within the Trust and is a standing item on the board agenda. We also heard from the senior management team that job plans for educational and clinical supervisors are being reviewed to ensure that educational activities are accurately reflected.

5 We heard from the senior management team that the Trust works closely with the Hull York Medical School to provide 40% of their clinical placements of which half are based in the community. Furthermore we heard that the medical education and clinical skills facility at Hull Royal Infirmary site provides medical students and doctors in training the opportunity to undertake practical skills training in a safe and controlled environment and that patient experience is incorporated into simulation training.

6 It is apparent that the pressure to provide education and training whilst maintaining service delivery is proving to be a challenge. The Trust appears to have a satisfactory working relationship with both the medical school and Local Education and Training

Board (LETB) with which it is associated, however in order to improve the quality of education and training delivered by this Trust this should be developed further.

Areas of exploration: summary of findings **This section identifies our findings in areas we agreed to explore before the visit.**	
Student assistantships & preparedness	The foundation year one (FY1) doctors we met with had only been in post a number of weeks and as such were still familiarising themselves with their role. Those who had shadowed an FY1 doctor prior to taking up post had found the experience useful although they would have liked this to be for longer than two days. The foundation year two (FY2) doctors we spoke with agreed that their medical school had prepared them well for their post.
Transitions and transfer of information	From our discussions on the day, it would appear that the Trust has a good working relationship with the medical school and LETB. We heard that in the majority of cases information between the organisations is transferred in a clear and timely manner, but that on occasion and in particular with reference to less serious concerns, information may not be received until after a foundation doctor has taken up placement. We also heard examples of where this information may be received by the Trust from the doctor themselves rather than via the LETB. The mechanism by which the Trust conveys information to the LETB (such as following a serious untoward incident or the doctor in training being the subject of a complaint) was described and appeared satisfactory; this was reviewed as part of subsequent visits to the medical school and LETB. Those responsible for delivering training, which includes the medical school, LETB and employer, must share information that is relevant to the development of the doctor.

Induction	Those we met described variable experiences with regard to induction, for example some of those we met with had face to face inductions whilst others undertook inductions via video. Video inductions were generally considered to be thorough, although some would have liked the opportunity to seek clarification or ask further questions. Clinical induction, which had been highlighted as a below outlier in the NTS for both emergency medicine and surgery, was considered by many of those we met within those specialties to be good. The visiting team was informed that induction had been specifically identified by the education management team education as an area for improvement. The visit team were informed that attendance at departmental induction is being monitored by the medical education team.
Placements and curriculum delivery	Both foundation doctors and doctors in training in obstetrics and gynaecology and emergency medicine described their workloads to be high. The need to provide service delivery meant that, on occasion, they missed out on training opportunities such as attending clinics or spending time in theatre. Workload had been identified in the NTS as a below outlier for doctors in training in emergency medicine and those we met with explained that this is due, in part, to the number of patients passing through the emergency department. Working patterns must be appropriate for learning and doctors in training must be given the opportunity to acquire new skills by attending theatre sessions and outpatient clinics. We heard that doctors in training in Obstetrics and Gynaecology experience difficulty accessing ultrasound training – See requirement 4. Some foundation doctors with whom we met were unclear with regard to how their placement met the requirements of the foundation curriculum. See recommendation 4.
Assessment &	Feedback was identified within the NTS as a below

feedback	average outlier for emergency medicine. The emergency medicine doctors in training we met with described the feedback they received as good but stated that, due to the pressure of work, supervisors did not always have time for educational activities although they did their best in difficult circumstances.
Supervision	Whilst the NTS did not indicate any concerns with regard to clinical supervision within any of the specialties we visited, patient safety concerns were raised with regard to the supervision of foundation doctors within the emergency medicine department and doctors in training in obstetrics and gynaecology. Please refer to requirements 1&2. Those doctors in training with whom we met confirmed that they have a named educational and clinical supervisor. We heard of some difficulties contacting colleagues based at Castle Hill Hospital as staff do not carry hospital bleeps and mobile phone coverage is variable.
Handover	During the visit we heard mixed experiences with regard to handover. Whilst some of those we met with described a very formal handover process, for others it was less so. We heard that handover is an issue that has already been identified by the Trust as an area for development. Please refer to recommendation 3.
Patient safety	Four patient safety issues were identified during the visit. Please refer to the requirements section below. We heard that Serious Untoward Incidents (SUIs) are reported electronically and reviewed by the Director of Medical Education (DME). From discussions on the day, it would appear that an internal review is commissioned by the DME however there didn't appear to be a set timeframe for this to occur, with examples given of the most serious concerns being reviewed ahead of others.

	Foundation doctors and the doctors in training we spoke to had limited experience of using the SUI reporting system. Those with experience of the process reported receiving an email acknowledgement of the submission and whilst arrangements were then made to discuss the issue with their educational supervisor, this appeared to be an informal meeting rather than part of an agreed process to be undertaken within a set timeframe. The educational supervisors we met with confirmed that whilst they are notified of SUIs by the senior management team, they are not party to discussions undertaken as part of the internal review. The visit team was reassured to hear that any doctor involved in an SUI is required to undertake reflective practice and is offered appropriate support. The Trust confirmed that SUIs involving medical students or doctors in training are reported to the medical school or LETB as appropriate.
Doctors in difficulty/fitness to practise	From discussions that took place throughout the visit, it would appear that there are mechanisms in place within the Trust to convey serious concerns but not so for low level concerns. In such cases, an educational supervisor may only learn of a particular issue during their first meeting with the doctor in question, which could be up to six weeks after they have started a placement. We also heard that the Foundation Training Programme Director meets once a month with the Director of Medical Education to discuss doctors in difficulty.
Training for trainers	From documentation provided ahead of the visit, we learnt that the LETB provides online and face to face training for educational and clinical supervisors. Online training packages are undertaken and monitored using a bespoke learning portal. Within the Trust, compliance is monitored by the medical education team, and we heard that trainers

	are sent reminders when further training is due. We heard both from the Trust and the trainers we met with that much effort has been put into updating and maintaining training records in order to comply with GMC requirements for the recognition and approval of trainers.
Equality & diversity	We heard that equality and diversity training is provided to all doctors during induction. No concerns were identified by the visit team.
Bullying and undermining	The visit team found no evidence of bullying and undermining within any of the specialties visited.
Quality control processes	We heard that the Trust gathers information from a number of different sources such as the LETB, medical school and their own educational department to inform quality control processes. Specifically, we heard how the Trust uses information from student end of placement surveys and the NTS to identify areas of concern. The Trust undertakes a programme of quality assurance visits to those GP practices involved with undergraduate teaching and also engages with the medical school and LETB to address actions identified during both routine and non-routine visits.

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	TTD1.2	Doctors in training conducting outpatient clinics in obstetrics and gynaecology must be appropriately supervised at all times.

2	TTD1.2	Foundation doctors in training in the emergency department must have access to appropriate levels of supervision when discharging patients.
3	TTD1.2	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.
4	TTD5.1	Adequate access to ultrasound training must be provided such that doctors in training are confident that they will able to meet the requirements of their curriculum.

Requirement 1: Doctors in training conducting outpatient clinics in obstetrics and gynaecology must be appropriately supervised at all times.

7 During the visit we heard from doctors in training in obstetrics and gynaecology at grade ST4 and above that they conduct outpatient clinics without direct access to supervision and this was confirmed by the educational and clinical supervisors with whom we met. We heard that if senior review is required and not available then patients may be called back when senior review is available.

8 Those supervising the clinical care provided by doctors in training must be accessible and approachable at all times while the trainee is on duty.

9 As this is a patient safety concern, we raised this with the Trust and Health Education Yorkshire and the Humber at the close of our visit. The Trust took immediate steps to ensure that doctors in training grades ST3-ST5 inclusive are not left without supervision in antenatal or gynaecology clinics.

10 We also heard that at weekends the gynaecology ward is closed and that, dependent on their condition, patients are moved to either an acute surgery ward or ophthalmology ward. It was unclear to the doctors in training we met with the criteria used to assess the condition of each patient to ensure that they are moved to the most appropriate ward. Clinical and educational supervisors confirmed to the visit team that the decision to move patients should only ever be made by a consultant, who by virtue of their grade would have the appropriate level of knowledge required to make such a judgement, however there is a risk to patient safety should this not occur. As this is not a training issue but may be a patient safety concern related to service, this was referred to the Care Quality Commission for review.

Requirement 2: Foundation doctors in training in the emergency department must have access to appropriate levels of supervision when discharging patients.

11 We found there to be severe service pressures on those working within the emergency department. This appeared to be a result of several different factors including larger than expected numbers of patients being seen in the emergency department and rota gaps. Furthermore, we heard that whilst patients are awaiting transfer onto the wards they remain under the care of staff within the emergency department and that this adds significantly to their workload. Although a new emergency department is due to open within a matter of months, those we met with felt that this would not help to alleviate workload pressures which, fundamentally, are the result of staff shortages and the current care pathway.

12 We heard from the doctors in training we met with and their supervisors that due to the geography of the department and staff shortages that it is not always feasible for consultants or an equivalent to supervise the care given to every patient. Doctors in training must be appropriately supervised according to their experience and must not be put in a situation where they are asked to work beyond their level of competence or without appropriate support and supervision. There must be access at all times, to a more experienced doctor with whom they can check their diagnosis and management plan should this be required.

13 We were told that, although it is discouraged, a patient could be seen and discharged by a FY2 doctor without prior referral to or discussion with a more senior colleague and whilst there are national guidelines that state when a FY2 must seek senior review prior to discharge, the trust must ensure that for all other scenarios appropriate support is available when needed.

14 This was raised as a serious concern on the visit with both the Trust and HEYH. The Trust responded by stating that the risk has already been recognised and that actions have already been taken to mitigate the concern. This issue will now be subject to enhanced monitoring.

Requirement 3: 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.

15 Throughout the course of the visit, medical students, doctors in training and their supervisors made repeated reference to the term SHO (Senior House Officer). It was apparent that this term is used to collectively refer to doctors in training from a number of different grades including foundation doctors' years one and two and those in core training.

16 The term 'senior house officer' or 'SHO' provides ambiguity for doctors in training, as it does not specify the level of training of the individual doctor. 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.

Requirement 4: Adequate access to ultrasound training must be provided such that doctors in training are confident that they will able to meet the requirements of the curriculum.

17 Basic ultrasound modules are a mandatory component of the Obstetrics and Gynaecology core curriculum, however doctors in training in obstetrics and gynaecology and their clinical supervisors confirmed that there is no ultrasound training available within the Trust, although simulation training is available at York.

18 Doctors in training must have access to facilities that will enable them to meet the requirements of their training programme as specified in the curriculum.

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	TTD1.2	Foundation doctors should not sign discharge letters that they themselves have not written and for patients with whom they have had no prior contact.
2	TTD6.10	The Trust should clarify and prioritise the range of initiatives described to the visiting team to address workforce issues which affect education and training using the role of the Chief Medical Officer in the broader health community partnerships.
3	TTD6.1	There must be formal, well organised handover arrangements in place across all specialties.
4	TTD5.2	Foundation doctors must be made aware of the requirements of the foundation curriculum and how their clinical placements enable them to meet the competencies required of them.

Recommendation 1: Foundation doctors should not sign discharge letters that they themselves have not written and for patients with whom they have had no prior contact.

19 We heard from foundation doctors in surgery that they are often required to sign discharge letters for patients that they haven't seen. These discharge letters are often attached to prescriptions. Consultants we spoke with confirmed this practice but added that the pharmacist would check the prescriptions for any errors.

20 We raised this issue as a concern during the visit. The Trust responded immediately stating that all Foundation and other level doctors in surgery will be advised to only complete immediate discharge letters related to their primary speciality and that these letters must be started, completed and signed the day before discharge. Doctors in training will be informed of this during induction and will be monitored by Clinical Leads of all the surgical specialities.

Recommendation 2: The Trust should clarify and prioritise the range of initiatives described to the visiting team to address workforce issues which affect education and training using the role of the Chief Medical Officer in the broader health community partnerships.

21 As with other Trusts in the region, we heard from many of those we met with that recruitment and retention of staff is an ongoing concern.

22 Doctors in training and their supervisors all described the impact of rota gaps both on service delivery and training. We heard how rota gaps increase pressure on staff, affect levels of supervision and limit the training opportunities available.

23 We heard that, in order to address current staff shortages, the Trust has employed a number of overseas doctors through the Medical Training Initiative. We also heard how, in the past, the Chief Medical Officer has worked with Clinical Commissioning Groups to identify solutions to the workforce issues currently being faced in emergency medicine.

24 We heard that the Trust is liaising with staff to identify ways to address the shortfall in junior doctor numbers Trust and is now seeking to work more closely with the Hull York Medical School and Local Education and Training Board to review and plan both present and future workforce requirements, including ways to attract and retain doctors in the region.

25 It is suggested that the Trust identifies and prioritises initiatives such that it is in a position to better address immediate workforce issues and adapt to future changes in healthcare delivery.

Recommendation 3: There must be formal, well organised handover arrangements in place across all specialties.

26 Foundation doctors and doctors in training provided the visit team with a mixed picture with regard to handover.

27 Doctors in training obstetrics and gynaecology described a formal handover process for obstetrics at which there was a consultant present in the morning.

28 Handover for foundation doctors in surgery varied between the two hospitals (Hull Royal Infirmary and Castle Hill). At Hull Royal Infirmary, we were told that foundation doctors have created their own handover checklist, a copy of which is stored electronically. In contrast, we heard that at Castle Hill Hospital, a verbal handover is conducted as there is no room available in which to conduct a formal process.

29 It was unclear whether, on occasion, handover is being undertaken between foundation doctors of the same grade although it was suggested that this would not be the case for issues considered to be other than routine. This presents a potential patient safety concern as junior doctors of the same grade are likely to be less clinically aware than more senior colleagues.

30 Handover in emergency medicine involves a sticker system detailing tests that have been undertaken to date, test results that are pending and an outline of the proposed treatment plan for the patient. Foundation doctors, specialty doctors in training and their supervisors confirmed that handover does occur between junior doctors but, that for less well patients, handover will be between registrars and consultants. Due to the size of the department it is not possible to conduct a departmental handover however we were told that a 30 minute cross over between shifts has been incorporated into the rota.

31 We heard from the education management team that handover is an issue that has already been identified as requiring improvement. A quality improvement team has been appointed to consider who should be involved in the handover process, where it should take place, what time and the documentation required. It is recommended that the review should also consider the issue of handover between junior doctors of the same grade and issue guidance accordingly.

Recommendation 4: Foundation doctors must be aware of the requirements of the foundation curriculum and how their clinical placements enable them to meet the competencies required of them.

32 We heard from the education management team that, the Foundation Training Programme Director (TPD) meets with doctors in training as part of their induction to explain how clinical placements link to curriculum competencies, and that the TPD is available to meet with individuals as and when necessary.

33 Despite this, foundation doctors we met with were unclear how their role met the requirements of the foundation programme curriculum and some felt that pressure to

provide service delivery detracted from the education and training opportunities available.

34 Regular contact with the Training Programme Director appeared to vary between foundation years 1 and 2, with some foundation doctors describing regular meetings to discuss the e-Portfolio, whilst others appeared to have little if any contact.

35 Action should be taken to ensure that foundation Doctors are aware of how their clinical placements enable them to meet the requirements of the foundation curriculum.

Acknowledgement

We would like to thank the Hull & East Yorkshire Hospitals NHS Trust and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.