

Visit to Royal Lancaster Infirmary

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	17 October 2013
Site visited	Royal Lancaster Infirmary, University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBNFT).
Programmes reviewed	Undergraduate (Lancaster Medical School) Foundation Programme General Practice in secondary care
Areas of exploration	Patient safety, support for and supervision of doctors in training, local quality control processes, management of education across UHMBNFT, access to educational opportunities, undermining, doctors in difficulty, consultant job planning and education, reconfiguration.
Were any patient safety concerns identified during the visit?	No
Were any significant educational concerns identified?	No

Has further regulatory action been requested via the responses to concerns element of the QIF?

No

Summary

- 1 Royal Lancaster Infirmary (RLI) was visited as part of our regional review of undergraduate and postgraduate medical education and training in the north west of England. The visit focussed primarily on doctors training in general practice (GP) and on the Foundation Programme, and undergraduate medical students from Lancaster Medical School, which is in the process of decoupling from Liverpool Medical School. RLI is one of three acute sites within University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBNFT). The others are Furness General Hospital and Westmorland General Hospital, the latter delivers mostly community care services. The local education providers (LEPs) within UHMBNFT are relatively isolated from each other in geographical terms. At the time of our visit, UHMBNFT was the subject of enhanced monitoring in relation to a patient safety issue and investigation at Furness General Hospital. UHMBNFT is the sole provider of acute secondary care placements to students from Lancaster Medical School, which is in the process of decoupling from Liverpool Medical School.
 - 2 The broader context is a particularly important influence on many aspects of training: uncertainty about reconfiguration, geographical isolation and difficulties in recruitment contribute to many of the difficulties faced by RLI.
 - 3 Overall, we heard that RLI was providing a good educational experience in most areas. It has identified and put in place improvements in some aspects of the education delivered and intends to carry out further enhancements. Both students and doctors in training we met were receiving good teaching and clinical experience. RLI has responded to patient safety concerns at its sister LEP, Furness General Hospital, by introducing new staff and reconfiguring the locations of wards, and we heard there was now a culture of doctors in training being encouraged to report safety issues.
 - 4 There are a number of areas we identified for improvement. RLI is operating in an environment of continuing uncertainty over the future configuration of services, and recent delays in producing a service improvement plan, and a timetable for consultation may impact on the ability to plan for the future.
 - 5 While we welcome many of the changes RLI has made in response to patient safety concerns at Furness General Hospital, we consider that
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further improvements should be made. The current design of rotas for foundation year 2 (F2) to core training year 2 (CT2) grade doctors does not yet guarantee a consistently appropriate level of ward cover at night. We also heard this can sometimes be exacerbated by the use of outdated terminology. There are also some difficulties with the delivery of education and training: we found that there was not a consistent approach to ensuring there was adequate educational time in consultant job plans across RLI. We also noted that a small number of doctors were not released to attend scheduled educational sessions. We also found there was a lack of clarity amongst doctors in training about the ways they can raise issues about their training with RLI. Finally, access to, and use of information technology to support clinical practice and videoconferencing facilities to support communications with other LEPs within UHMBNFT could be improved.

Areas of exploration: summary of findings

Patient safety/ support for and supervision of doctors in training

RLI has put in place a number of measures to enhance patient safety in response to quality management data and patient safety issues at other LEPs within UHMBNFT. These include the reconfiguration of buildings, the recruitment of additional clinical staff and the introduction of an innovative approach to promote the reporting of patient safety issues.

Some aspects of rota design and terminology mean that an appropriate level of cover is not always guaranteed. The design of rotas can mean that on occasions, doctors who have not been able to develop a good level of experience in their roles are working on wards without an appropriate level of supervision, which is not conducive to patient safety.

See [area of improvement 1](#) and [requirement 1](#)

<p>Quality control</p>	<p>Education issues are considered regularly at education management meetings which are chaired by the Director of Medical Education (DME) and include members from the Trust management. The DME is also a member of the Trust Management Board. Doctors in training and students considered education to be well managed. They cited examples of routine reporting and monitoring processes being used to address patient safety and education issues. They could also provide examples, and of planned action being taken to address such issues.</p> <p>Standards are being met for aspects of quality control we investigated on the visit.</p>
<p>Management of education across UHMBNFT</p>	<p>UHMBNFT is appointing new consultants to 'cross bay' posts, meaning they will work at both Furness General Hospital and Royal Lancaster Infirmary. The LEP intends that cross bay appointments will improve communication within UHMBNFT.</p> <p>We found that there was still limited access to, and use of videoconferencing facilities to support the management of education across sites.</p> <p>See recommendation 2</p>
<p>Access to educational opportunities</p>	<p>Students and doctors in training reported that they receive a good educational experience at the LEP. Doctors in training are mostly released to attend scheduled teaching. We heard some examples of doctors training in general practice (GPSTs) not being released to attend teaching. There were also some isolated incidents of doctors training on other programmes not being released for scheduled education sessions.</p> <p>See recommendation 1</p>

Undermining	<p>We found that RLI identifies and addresses incidents of undermining appropriately.</p> <p>Undermining had been identified in a department through the GMC National Training Survey (NTS) in 2011 and 2012, and this had been investigated and resolved.</p> <p>Standards we investigated on the visit relating to bullying and undermining are being met.</p>
Doctors in difficulty	<p>Training on supporting doctors in difficulty is part of mandatory training for educational and clinical supervisors and there are local forums for discussing how best to support doctors experiencing difficulty while training. Training is also given to those administrative staff who are involved in supporting doctors in difficulty.</p> <p>Standards we investigated on the visit relating to supporting doctors in difficulty are being met.</p>
Consultant job planning and education	<p>We found a wide range of job planning practices within individual departments in the LEP. While some of the supervisors we met had appropriate time for education allocated in job plans, this was not the case within and across all departments.</p> <p>See requirement 3</p>
Reconfiguration	<p>There is continued uncertainty regarding the proposed reconfiguration of UHMBNFT, and we noted that the timetable for consultation has been delayed.</p> <p>This issue was identified for further exploration at the visit to Health Education North West (HENW) on 20-21 November 2013. Please see the visit report for HENW for further information on this area.</p>

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.

- 6 We visited Furness General Hospital and Lancaster Medical School in 2013 as part of the New Schools quality assurance process and identified

a number of items of good practice at undergraduate level. We were pleased to note the maintenance of good practice previously identified as well as the following area of improvement.

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 <i>Tomorrow's Doctors / The Trainee Doctor</i>	Areas of improvement for the LEP
1	TTD domain 2 standard	RLI's response to quality management data and patient safety issues at other LEPs within UHMBNFT, resulting in changes to staffing and ward configuration to improve patient safety.

Area of improvement 1: Changes to staffing and ward configuration to improve patient safety

- 7 The GMC NTS raised issues with clinical supervision in medical posts in particular, and UHMBNFT is under scrutiny from several regulators in relation to patient safety issues at Furness General Hospital. We investigated these issues at RLI with managers, supervisors of GPSTs and foundation doctors and doctors in training. Senior management and educational staff identified a number of changes that had been made in response, notably the recruitment of six advanced nurse practitioners to support the emergency department, which had been reported as having a high workload. There has also been reconfiguration of medical wards, with the amalgamation of six wards and the movement of the amalgamated ward to a location close to the acute medical ward. We heard that prior to the movement of the wards, large numbers of patients on some medical wards had been dispersed around the site. This had made it difficult to manage patients and ensure there was sufficient cover on the wards.
- 8 We also heard about how RLI had responded to a joint inspection by the Care Quality Commission and Monitor in relation to patient safety issues at Furness General Hospital. RLI has attempted to improve the rate of reporting of clinical incidents by encouraging doctors in training to file patient safety reports, and changing the system for investigating clinical incident reports. Foundation year 1 and 2 doctors were aware of the

system, confirmed they were encouraged to use it and cited examples where they had reported incidents which had been investigated, with changes being made and fed back to the doctors who had raised the report. The LEP is also planning to introduce dedicated spaces ('safety stations') with information to promote patient safety and to provide a space for staff to report potential or actual patient safety concerns easily and quickly. It is anticipated that these will also be available for patients in future but this has not yet been confirmed.

- 9 We welcome the actions RLI has made to improve patient safety. The foundation doctors we met were confident in the system for reporting patient safety concerns and we consider the reconfiguration of wards to allow for better care and the introduction of additional staff in the emergency department to be positive changes. We noted that many of the changes are relatively recent and their effectiveness still needs to be confirmed through monitoring. We also identified continuing issues in relation to the design of rotas (see paragraph 10). Despite this, we consider that actions taken have ensured there is a strong culture of reporting patient safety incidents and that changes to staffing and reconfiguration of wards are likely to have a positive impact on patient safety.

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 <i>Tomorrow's Doctors / The Trainee Doctor</i>	Requirements for the LEP
1	TTD 1.2, 1.5	Ensure that rotas use current terminology when referring to the grades of doctors in training.
2	TTD 1.2, 1.5	Ensure that rotas consistently provide cover from doctors with a range of skills that is sufficient to manage a ward at night and provide clinical supervision as necessary.

3	TTD 8.4 TD 162	Put in place a clear and consistent policy across all departments to make sure that there is adequate time for both undergraduate and postgraduate education in consultant job plans.
4	TTD 5.2, 5.20	Clinical supervisors of GPSTs must be familiar with the GP curriculum and have access to the GP e-portfolio.

Requirement 1: Make sure current terminology is used in the design of rotas

- 10** 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.
- 11** In particular, we noted the use of the term 'senior house officer' (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 similar 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: Make sure that rotas consistently ensure there is an appropriate level of competency to manage wards and provide support and supervision at night

- 12** While RLI has put in place a number of changes to improve patient safety, we consider there are still problems with the terminology and design of rotas. We found that rotas did not adequately distinguish between doctors of varying levels of competency, nor did they ensure that there was a doctor with a consistently appropriate level of expertise on duty at night and weekends to manage the wards and supervise F1 doctors. RLI operates a 'senior house officer' (SHO) rota to cover wards at night and provide immediate clinical support and supervision to F1 doctors. The rota includes F2 to CT2/ST2 grade doctors in training or equivalent non-training doctors (see [requirement 1](#) above).
- 13** Foundation doctors we met stated that rotas were generally highly pressured in terms of the workload and expressed particular unhappiness with the medical on call rotas at night and weekends (although a few of the doctors we met advised that similar issues sometimes occurred on surgical rotas). As well as the heavy workload, foundation doctors

considered that the level of direct support and supervision from the 'SHO' on duty could be variable and noted that they were left to manage wards largely by themselves, although were confident that they could access support from middle grade doctors and consultants based off-site if they requested it (some surgical middle grade doctors and consultants are based off-site during on calls, but must be available within 20 minutes.)

- 14** Some of the foundation doctors we met also cited examples where newly appointed F2s with little experience were the most senior doctors immediately available to provide support and supervision. F2 doctors we met advised that they often had to explain to nurses or other doctors that they were an F2 (and not a CT1-2 or ST1-2) grade 'SHO' and stated that it was only once they had become well known to other clinical staff that their level of competency was understood. The doctors in training we met did not identify any situations where this had led to patient safety incidents occurring, but considered the arrangement were not conducive to patient safety.
- 15** We heard from senior staff that the high level of vacancies was affecting the ability of RLI to ensure rotas were filled, and that weekly meetings took place to ensure the rota for the coming week was fully staffed. We also heard an example of the education management team providing targeted additional support to doctors to help them carry out their night on call duties.
- 16** We accept that much of the unhappiness of foundation doctors relates to workload pressure and difficulties with recruitment, but consider that the terminology and rota design is not conducive to doctors working within their competence. The use of the 'SHO' terminology is potentially confusing, and we heard examples from foundation doctors where this had led to them being placed in situations where they were not always confident in their own competency or that of their immediate supervisors to deal with certain clinical issues. We do not consider that the rota guarantees a consistently appropriate level of competency and experience on the wards, particularly in situations where there are relatively inexperienced F2 doctors on duty early on in their placements. RLI must ensure that current terminology is used to design rotas and that rotas consistently ensure that there is appropriate cover on wards.

Requirement 3: Ensure appropriate time for education is included in consultant job plans

- 17** We found that not all consultants had educational time recognised in their job plans, or that the recognition of this time was not always

consistent. Clinical supervisors of both students and doctors in training reported a wide range of allocation policies and recognition of time for training in job plans, and noted there were pressures on the time allocated for education. The reason for the wide variation was reported to us as being a result of individual departments being responsible for setting their own policies, not articulating clear policies on job planning, or individual clinicians not having job planning meetings.

- 18** Clinical supervisors from several different specialties told us that the allocation of educational time for undergraduate education is particularly inconsistent. The management team recognised this, and have appointed a consultant with responsibility for incorporating undergraduate education in job plans. Education management staff stated that they had intervened to try and ensure individual consultants had appropriate job plans. However, RLI must ensure that time is consistently and appropriately allocated for education across all departments.

Requirement 4: Clinical supervisor familiarity with the GP curriculum and access to the e-portfolio

- 19** Clinical supervisors of GPSTs in secondary care we met experienced difficulties in accessing the GPST e-portfolio. They were often reliant on the GPSTs they supervised to help them navigate the e-portfolio. They also noted that their knowledge of the curricular requirements for GPSTs was limited and they had received very little training on the specific needs of GPSTs.
- 20** GPSTs we met reported that it was often not recognised that they were on a different programme to doctors on programmes such as CMT, and encountered difficulties in tailoring their learning opportunities their future careers as GPs. While they valued the clinical exposure and support they received in paediatrics and emergency medicine, we heard that they did not consider they were being prepared for GP roles. Some had also experienced difficulty in attending GP teaching.
- 21** We consider that the quality of educational supervision and clinical experience for GPSTs in secondary care could be improved by improving clinical supervisors' knowledge of the GP curriculum, and by supporting their access to the GP portfolio. We have identified opportunities for closer working between hospital clinical supervisors and educational supervisors in local GP practices in recommendation 3 below.

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 <i>Tomorrow's Doctors/ The Trainee Doctor</i>	Recommendations for the LEP
1	TTD 5.4	Ensure all GPSTs are released for scheduled teaching.
2	TTD 7.1, 8.5 TD 152	Improve the access to, and use of, videoconferencing technology and computers and phones on wards. This will support the discussion of education issues between the different LEPs within UHMBNFT, and support doctors in training to access systems to support clinical practice and education on wards.
3	TTD 6.8, 7.3	Take advantage of the geographical proximity of local GP training practices to develop links between supervisors of GPSTs in primary and secondary care.
4	TTD 6.7	Clarify and communicate to foundation doctors the different meetings where they can raise issues about their training at the LEP.

Recommendation 1: Ensure all GPSTs in training at the LEP are able to attend scheduled education sessions

- 22** We found that the majority of doctors in training were able to access, and encouraged to attend, scheduled teaching and education sessions. This was particularly the case for foundation doctors, however GPSTs were not being universally released to attend educational sessions.
- 23** Foundation doctors in training receive one day's teaching specific to the Foundation Programme every two weeks, with the exception of those training in the emergency department, who receive a half day teaching each week. This is to accommodate the workload requirements in the emergency department. Although this arrangement is generally working, we noted that foundation doctors in emergency medicine were not released for a mandatory careers session. RLI had noted this and stated that this would not be repeated the following year.

- 24** General Practice Specialty Trainees (GPSTs) were not always released for scheduled education sessions, and teaching sessions could be interrupted by queries and requests related to their ward work. There was anxiety amongst the GPSTs that they would not meet mandatory levels of attendance required for their programme.
- 25** The experience of the GPSTs reflects similar concerns previously raised in RLI's annual report (2012) submitted by Health Education North West (HENW). It is clear that RLI places considerable emphasis on ensuring foundation doctors are able to attend scheduled teaching, but our findings in relation to GPSTs indicate this is not consistent across RLI.

Recommendation 2: Improve access to, and use of information technology (IT) supporting clinical practice and communication between different LEPS within the trust

- 26** The different LEPS within UHMBNFT are geographically isolated from each other. RLI and Furness General Hospital are separated by the Kent Channel and a significant road or rail journey is required to travel between them. This makes it difficult for clinicians who work at the different sites to communicate about education issues in person, although there have been some recent cross bay consultant appointments made which are intended to address this.
- 27** The management team and clinical supervisors told us that video conferencing facilities remained limited, and were used primarily to support service. There is an opportunity to improve the access to videoconferencing facilities, and to support education staff at all LEPS within UHMBNFT to use these facilities to discuss education issues and ensure that education staff at all LEPS have good access to advice and support from colleagues.
- 28** We met doctors in training who told us that there are limited IT resources supporting clinical practice, such as telephones and computer terminals. We also heard that problems with some of the software used for portfolios meant that using the IT systems could be difficult and time consuming, as frequent restarts were required. This placed further pressure on the resources available. RLI should improve access to, and use of, IT resources supporting education and clinical practice.

Recommendation 3: Develop links between GP trainers in primary and in secondary care

- 29** We found that there are opportunities to achieve better communication between the components of GP training taking place in primary care and in secondary care (see [requirement 4](#) above). Both educational and clinical supervisors of GPSTs reported that there was limited interaction between the educational and clinical supervisors, and that a number of potential improvements to training could be made by addressing this.
- 30** Educational supervisors of GPSTs reported that some clinical supervisors' reports could provide better feedback about GPSTs: we heard of GPSTs performing poorly in hospital placements but their educational supervisors based in local practices were not notified. Clinical supervisors themselves cited difficulties with their use of e-portfolio as an obstacle in providing feedback and information about the GPSTs they clinically supervised. Despite this, educational supervisors are heavily reliant on clinical supervisors' use of the e-portfolio to get feedback about GPSTs' performance when based in secondary care and to support their educational development. Clinical supervisors also reported a lack of knowledge about the GP curriculum, and the supporting e-portfolio.
- 31** The quality of both educational supervision and clinical supervision for GPSTs could be enhanced by developing closer links between the two. While some of the difficulties with the e-portfolio are beyond the control of the LEP or HENW, there are opportunities for closer working to develop at a local level. Many of the practices where educational supervisors of GPSTs are based are very close to RLI. This presents a particular opportunity to develop links between primary and secondary care training for GPSTs.

Recommendation 4: Clarify the ways in which foundation doctors can raise issues about their placements at RLI

- 32** The forums in which foundation doctors can raise issues or provide evaluation about their training at RLI are not well understood. Supervisors of foundation doctors identified quarterly 'Foundation Forums' and weekly drop in sessions as the main forums for foundation doctors to raise issues about their training.
- 33** Despite this, both the F1 and F2 doctors we met were mostly unable to identify these forums. RLI should raise the profile of the forums for doctors in training to provide evaluation of their training.

Acknowledgement

34 We would like to thank the Royal Lancaster Infirmary and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.