General Medical Council

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Visit to Royal Preston Hospital

This visit is part of a regional review and uses a risk-based approach. For more information on this approach see http://www.gmc-uk.org/education/13707.asp.

Review at a glance

About the visit

Visit date	18 October 2013
Site visited	Royal Preston Hospital (RPH)
Programmes reviewed	Undergraduate Manchester Medical School (MMS), foundation training, paediatrics, neurosurgery.
Areas of exploration	Patient safety; transition to LETB; quality management; student support.
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 The North West of England was selected for the 2013-2014 Regional Review. The Manchester visit team visited Royal Preston Hospital (RPH) in the Lancashire Teaching Hospitals NHS Foundation Trust (LTHNFT) as a Local Education Provider (LEP). They provide around 250 undergraduate placements for Manchester Medical School (MMS).

2 It is clear that RPH places a strong importance on education. The Education, Training and Research Subcommittee reports directly to the Trust Board and is chaired by the Chief Executive of LTHNFT. RPH also has ring-fenced and auditable education funding which means it can clearly see where SIFT money is spent. There are robust quality control systems and excellent education facilities. All the students and doctors in training that we met praised the simulation training provided by RPH.

3 In line with many LEPs across the UK, RPH is dealing with capacity pressures which could present a risk to educational experience, vacancies in training posts and threats with the availability of community placements.

Were any patient safety concerns identified during the visit?	A serious concern was raised by the foundation year 1 (F1) doctors who reported that patients were being moved, instigated by the bed manager and between clinical environments, against medical advice. We were informed of one patient who was due to receive a platelet transfusion, because of a low platelet count, but did not. The foundation doctor told us this was because the patient was transferred to another clinical environment. We were informed that this patient died the next day. Foundation year 2 (F2) doctors told us they had also experienced patients being moved against consultant medical advice, and they were concerned that this could compromise patient care plans. The Medical Director and the Foundation Programme Director told us that these cases had not been reported to them and the bed manager would always have consultant approval before moving a patient. The Medical Director agreed to use all available processes to investigate this issue and provide us with the relevant policies that are currently in place for patient transfer. After the visit the Medical Director undertook a further investigation of the RPH data system and identified a patient death, that was likely to have occurred even if the platelet transfusion had been given. We were provided with the review of the case, which identifies an issue, reported by a nurse, with nursing handover, but no concerns were raised about the appropriateness of the transfer. We were also provided with information concerning RPH's standard operating procedure for assessment of appropriate patients to be transferred and with the mechanisms and data for the review of those transfers. In light of this we did not refer this for enhanced monitoring but did set requirement 3 in this report and referred the case to Care Quality Commission.

Areas of exploration: summary of findings	
Patient safety	There were many aspects of patient safety explored on the visit. All doctors in training and their supervisors were aware of the processes in place for reporting patient safety issues including the Datix incident reporting system. Many foundation doctors had reported incidents on Datix but they were not advised on the action taken as a result of their reporting an incident. However the patient safety concern identified above was reported to the LEP by a nurse and not by the foundation doctor. Medical students at RPH wear grey scrubs on the ward, which is a good example of protecting patient safety, as staff are aware they are students and therefore conscious of their expected level of competency and the clinical supervision they require. See good practice 2
Transition to LETB	The senior management team reported that, as this transition is in the early stages of development, they have not been actively engaged with Health Education North West (HENW). They are not clear what HENW is responsible for or how this will impact funding streams. Although not involved in strategic development, they reported that they continue to have a good operational relationship with colleagues from the North Western Deanery who now work at HENW. This issue was identified for further exploration at the visit to HE North West 20-21 November 2013. Please see the visit report for HE North West for further information on this area.

Student support	The students were positive about their experience at RPH. They valued the breadth of clinical exposure available to them and were well supported. Students reported personal experiences of receiving great support from the undergraduate team who they described as approachable and helpful. Standards are being met in the aspects of student support that we explored on this visit.
Clinical supervision	Overall the doctors in training we met from paediatrics and neurosurgery were positive about their experience and the support they receive at RPH. We were informed that ST4 and higher paediatric doctors in training were unsupervised in clinics for approximately 30% of the time. See requirement 2
Quality control	The education management team provided us with quality control structures and diagrams and explained how they have developed their processes over time to improve triangulation of any issues detected. The process allows clear structures of accountability and feedback from students and doctors in training. Standards are being met in the aspects of quality control that we explored on this visit.

Relationship with MMS	RPH is the most distant clinical campus from the main MMS site and we wanted to explore how this impacted on its relationship and ability to access support and services from MMS. The education management team have formal management meetings with MMS and the LTHNFT hospital dean attends meetings with the other associated MMS hospitals deans and phase leads to discuss changes and interactions. The undergraduate supervisors were positive about their engagement with the medical school and could highlight a number of contributions they had made to curriculum development. Standards are being met in the aspects of the LEPs relationship with the medical school that we explored on this visit.
Equality and diversity	RPH has mandatory equality and diversity training once a year for all supervisors. The undergraduate and foundation educational and clinical supervisors that we met had all attended this training and knew the process for updating it. Standards are being met in the aspects of equality and diversity that we explored on this visit.
Transfer of information	Doctors in training in neurosurgery rotate frequently between RPH and Salford Royal Hospital during their training. Their supervisors from each site meet at least four times a year which allows thorough transfer of information. The education management team informed us that the undergraduate dean visits St Andrews School of Medicine to talk to the students who will transfer to MMS following completion of a three year honours degree and they discuss the transfer of information about the students with the staff. Standards are being met in the aspects of transfer of information that we explored on this visit.

Patient and public involvement	RPH have around 400 patients recruited to their "Patients as Educators" programme to be involved in undergraduate educational activities. These patients are trained to support teaching sessions, are examined by students, they talk about their conditions and attend seminars. RPH have also recently trained patients to sit on consultant appointment panels. Standards are being met in the aspects of patient and public involvement that we explored on this visit.
Lead employer arrangements	Pennine Acute Hospitals NHS Trust is the lead employer for the north west region and there are no issues regarding this for doctors in training or their supervisors at RPH. In the senior management team meeting it was mentioned that the information is sometimes received at very short notice, however it is noted that this is often related to timing of national recruitment rather than an issue with the lead employer or HENW.

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 I The Trainee Doctor*	Areas of good practice for the LEP
1	TTD 8.7	The use of simulation and clinical skills assessment for the assessment of foundation, ST1 and ST2 doctors before taking up their posts within the organisation.
2	TD 31	Undergraduate students from Manchester Medical School are clearly identifiable because they wear grey scrubs, this ensures healthcare professionals on the wards are aware of their level of competence and the clinical supervision they require.

Good practice 1: **The use of simulation and clinical skills assessments**

4 The LEP run skills assessments as part of its induction process. All grades of doctors in training from F1-ST2 are required to participate in the assessment of a range of common tasks they will have to undertake on the ward, including prescribing, life support, giving injections, taking blood samples and connecting drips to patients.

5 The senior management team informed us of this initiative and are pleased with its progress. If a doctor in training does not reach the required level they are given remedial training and are not put on any out of hours or on call shifts until their competence has been achieved. The foundation supervisors are very happy with these skill assessments on new foundation doctors and it allows them to recognise any F1s that need further support in certain areas.

6 This process enhances patient safety as it ensures that the doctors in training are competent or provided with support to meet the expectations of the LEP.

Good practice 2: **Undergraduate students are identified with grey scrubs**

7 Students in years 3 to 5 from MMS informed us that they are given grey scrubs, with the university's crest on them, to wear when they are on the wards. This helps the staff know what their competence levels are as they are not mistaken for doctors in training.

8 The students told us that there have been occasions when they were mistaken for cleaners and this was also highlighted in the annual sector review report for LTHNFT by Manchester Medical School in June 2012. They reported that the main issues were students being mistaken for cleaners or nurses and as a result the patients were hesitant to ask for help from them. In the LTHNFT reply to the report they were open to looking at alternative options and had therefore added the university crest.

9 We recognise this work with the undergraduate students as good practice, as it ensures patient safety by allowing staff on wards to identify students and therefore understand their expected level of competence and provide appropriate clinical supervision. We also understand the complications identified by the medical school report and the work between MMS and RPH will further improve this scheme.

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 I The Trainee Doctor*	Requirements for the LEP
1	TTD 1.2	Current terminology must be used when referring to the grades of doctors in training and designing rotas to ensure appropriate clinical supervision and expectations by others of a doctors' competencies.
2	TTD 1.2	RPH should provide reliable supervision for paediatric ST4 (and above) doctors in training during outpatient clinics.
3	TTD 1.10	Doctors in training must be made aware of the processes and systems in place when patients are transferred between different clinical environments.

Requirement 1: Using current terminology for grades of doctors in training and designing rotas

10 The education management team at RPH informed us on the visit that one of their areas for development at the LEP was to eliminate the term 'senior house officer' (SHO); however this term was consistently used by doctors in training and their supervisors during the visit. HENW made a recommendation to PRH in July 2013 to continue its work on eliminating this term.

11 It is important for current terminology to be used when referring to the grades of doctors in training particularly when designing and communicating rotas, to ensure appropriate clinical supervision and expectations of doctors' competence.

Requirement 2: Doctors training in paediatrics at ST4 and above should be supervised during outpatient clinics

12 In the 2013 NTS there was a comment from a paediatric doctor in training stating that there needs to be more time for supervised learning at RPH. During our preparation for the visit it was noted that there were rota gaps due to middle grade vacancies in paediatrics, and the education management team at RPH highlighted this to us on the visit as one of the organisational risks. The doctors in training and supervisors that we met in paediatrics all agreed that the rota is currently better than it was and there are no longer rota gaps; however it is still a busy department and if one staff member is away then it is extremely difficult to manage.

13 We were informed by the doctors training in paediatrics that ST4 and above are unsupervised during outpatient clinics for approximately 30% of the time. This is due in the main to clinics not being cancelled when consultants are on leave or away. The doctors in training told us that on average around one third of the clinics are unsupervised, although they did confirm that during their ST1-ST3 training they were never left unsupervised in clinics. The educational supervisors from paediatrics informed us that there is always a resident consultant on call but not based in the outpatient clinics, even though a doctor in training might see a patient first. They did however admit that doctors in training are left unsupervised on some outpatient clinics. RPH should ensure that there is always a consultant available to support paediatric doctors in training during outpatient clinics.

Requirement 3: Make doctors in training aware of the patient transfer process

14 During our visit at RPH, F1 doctors raised concerns about patients being transferred from one clinical environment to another without agreement by medical staff. They advised that the bed managers may make the decisions to move patients between clinical environments and they have more influence over transfers of patients than do the doctors. In our meeting with F2 doctors they echoed this concern and noted examples of patients being moved against consultant medical advice. Foundation doctors have concerns that inappropriate transfers result in patient care plans being compromised.

15 The Medical Director and the Foundation Programme Director informed us that they have not been made aware of bed managers overriding consultant medical advice during the transfer of patients. The Medical

Director advised it was policy that a patient should never be moved against consultant advice. The foundation doctors are unaware of the correct processes and responsibilities that are in place for the transfer of patients between clinical environments as we heard a variety of processes being followed.

16 In the 2013 NTS there were three patient safety comments from doctors in training at RPH who reported that patients are inappropriately moved, one of them specifically mentions that transferal of patients is usually the decision of a bed manager. Clear processes and protocols must be put into place to ensure that doctors in training understand the correct process of patient transfer. When a patient has been transferred and the doctor in training does not consider it was suitable it should also be clear with whom the doctor should raise their concerns.

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*l *The Trainee Doctor*	Recommendations for the LEP
1	TTD 1.5	The ST1-ST3 paediatric rotas should include time for morning and evening handovers.
2	TTD 5.4	RPH should ensure foundation doctors understand the structure of their scheduled teaching programme and how it relates to their educational outcomes.
3	TTD 5.7	RPH should ensure that the regional neurosurgery "mock" examination remains a formative assessment.

Recommendation 1: The paediatric department should include time for all handovers in the rota

17 In the 2012 and 2013 NTS paediatrics did not receive any results below the national average apart from one, in 2013, for workload. In 2013 there were also five negative comments submitted with the NTS regarding rota arrangements and long working hours. We explored these

findings during our two meetings with doctors training in paediatrics, one with ST1-3 and the other with ST4-8.

18 The ST1-3 doctors informed us that the paediatrics department is extremely busy however they were very positive about their experience and wide range of educational opportunities. The doctors training in both paediatrics and neonates told us they were happy with the level of support and supervision at RHP. The doctors in training that we met informed us that they often have to work longer hours in order to be present for handover, as their handover can be scheduled for an hour before or after the rota hours.

19 This was also noted in the minutes from an LTHNFT internal review focus group with 'junior grade' doctors training in paediatrics in July 2013. They told the focus group that the rota was demanding and it was difficult to take breaks when they are short staffed. It was also mentioned during the focus group that the doctors in training rarely leave on time due to handover starting when their shift ends. Although it was noted that the doctors in training did not see any risks to patient safety, we recommend that rotas include handover time to ensure their hours remain compliant with working time regulations.

Recommendation 2: RPH should make it clear to foundation doctors how the scheduled teaching programme relates to their educational outcomes

20 F1 doctors were positive about the clinical supervision they receive and the level of clinical experienced available. Some told us that they did not have a syllabus for teaching and others informed us that there was a syllabus but it was not followed as far as they could tell. They all agreed that the lectures they have are repetitive and that there appears to be no structure to their teaching. They told us that most of the time they find out what the teaching is at the beginning of that week.

21 The education management team advised that the foundation programme director has meetings at least three times a year with the regional foundation school to discuss the teaching programme and map it against the curriculum. Slight changes are made every year, so to ensure that they do not miss important topics, areas can sometimes be repeated. The foundation programme director told us that the programme can only be set two-three months in advance, as most of the teaching is in house they rely heavily on clinician availability. This programme schedule is then available online for foundation doctors. It appears that there is a miscommunication between the foundation

doctors and programme organisers and more work should be done to help the foundation doctors understand their educational programme.

Recommendation 3: RPH should make it clear to doctors in training that the regional neurosurgery 'mock' examination will remain a formative assessment

22 Neurosurgery at PRH performed well in the 2012 and 2013 NTS. It scored five areas above the national average and one below in 2012 and no areas scored below the national average in 2013. There was however one comment submitted with the survey in 2013 highlighting that the heavy workload of the department was impacting on patient safety. The doctors training in neurosurgery confirmed they are very satisfied with the quality of training they receive at RPH. Although there is a hard service commitment, they have very good clinical exposure and comprehensive training. RPH has also employed six nurse practitioners in the department and this has greatly improved training, as it means doctors in training can be freed from routine work to take advantage of educational opportunities.

23 The doctors training in neurosurgery were also highly positive about the local neurosurgery mock exam, following which they receive detailed personalised written feedback. The neurosurgery supervisors that we met are also pleased with the mock exam which they consider has been a unique and strong part of the training. This mock exam is comparable to the Royal College of Surgeons exam that the doctors complete in ST6 and it is used to judge how the doctors in training are progressing over the years. It was however suggested in our meeting with the doctors in training that RPH is planning to move away from making it a mock exam and it could impact on recommendations about progression at ARCP, particularly for doctors in ST5. While the doctors in training were supportive of the exam, clarification should be made on this matter to ensure it does not have summative status in later years.

Acknowledgement

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