General Medical Council

Visit to Sheffield Teaching Hospitals NHS Foundation Trust

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

Review at a glance

About the visit

Visit dates	16 October 2014
Site(s) visited	Northern General Hospital,
Programmes reviewed	Undergraduate (Sheffield Medical School) Foundation, core and higher specialty training in emergency medicine, obstetrics and gynaecology, and surgery.
Areas of exploration	Patient safety, clinical placements, transfers of information, and resources.
Were any patient safety concerns identified during the visit?	Yes
Concern	Doctors in training in F1 surgical posts were taking consent for certain procedures when they may not be competent to do so. F1s had some materials to induct them to these procedures but there was no confirmation that these were completed or that any competence assessment took place before they take consent.
Action Taken	We asked for an update in regards to the above. The Trust provided copies of the consent policy, training documents, and sign off process including

	information about how this will be audited and monitored. See requirement 5.
Were any significant educational concerns identified?	No
Has further regulatory action been requested via enhanced monitoring?	No

Summary

1 Northern General Hospital was visited as part of our regional review of undergraduate and postgraduate medical education and training in Yorkshire and Humber. The visit focussed primarily on doctors training in emergency medicine, obstetrics and gynaecology, undergraduate medical students from Sheffield medical school and those on the Foundation programme in surgery, although we did gather some evidence about experiences in other specialties. The Northern General Hospital is a major trauma centre and delivers most specialties on campus. They have the benefit of being financially stable and with many other hospitals close by the geographical region is one of the best to train in purely for the breadth of learning opportunities available.

2 We did have concerns that foundation doctors in some surgical posts were taking consent for procedures where they may not be competent to do so. In addition to this, handover was not always consultant led and varied between specialties which could potentially lead to patient safety issues - although it was reported to be working well during Hospital at Night. Workload was particularly high at this site which doctors in training said effected their exposure to learning opportunities.

3 Overall, we found that the LEP was committed to education and training at board level. Students and trainees were generally well supervised and supported, and placements are well-organised. Many former Sheffield medical schools attend postgraduate training at the site, so there is an awareness of the needs of different levels of students and doctors in training during teaching. There was a good awareness of human factors and non- technical skills across students and doctors in training. Hospital at night is working well and is rated by doctors in training.

4 Student assistantships for Sheffield medical students at this site are beneficial, however Foundation Year 1 doctors in training who are not from the area do not feel as supported as those who attended Sheffield when they first join the Trust.

5 Education, teaching and training in accident and emergency and anaesthetics was very highly regarded amongst medical students and doctors in training. However, this was not the case for all specialties; educational experience and satisfaction varies across the LEP.

6 In line with many LEPs across the UK, this trust is dealing with capacity pressures which could present a risk to the educational experience. Work intensity is generally very high for doctors in training and there is a real tension between education and service delivery, with doctors in training expected to fill service gaps.

Areas of exploration: summary of findings	
Patient Safety	There are some good initiatives around patient safety and also a number of potential risks: Outdated terminology is used when referring to grades of doctors in training, which could potentially lead to inappropriate expectations of their competence and the level of clinical supervision required (see requirement 2). Foundation year 1 and year 2 doctors (F1s and F2s) are, on occasions, taking consent without appropriate training and when they do not feel competent to do so (see requirement 5). Doctors in training and students had a very good sense of human factors and non-technical knowledge.
Clinical placements	There is a lot of variability in placements at this Trust. Anaesthetics, emergency medicine and obstetrics and gynaecology were spoken of highly. However the learning environment particularly in Acute medicine was a challenge to doctors in training and medical students due to the variability in support and procedures. (see requirement 3).
Transfer of information	No issues were highlighted in regards to Transfer of information. Clinical and educational supervisors were well informed about health or performance related issues with students or doctors in training as

	they began new posts at the Trust.
Resources	Doctors in training and medical students appeared satisfied with the resources available at the Trust and spoke highly of the number of specialties available in a close geographical area meaning that learning opportunities were plentiful.
Bullying and undermining	Students and doctors in training did not report issues with bullying and undermining and all felt supported to raise concerns if they needed to.

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	TTD1.6	Consultants must oversee handover and this must be scheduled in a way that ensures patient safety and continuity.
2	TTD 1.2, 1.5 TD 34	Terminology used to refer to and identify doctors in training must be such that patients and colleagues are aware of the status and training grade of each individual. The terms SHO must not be used.
3	TTD 6.10	Working patterns and intensity of work by day and by night must be appropriate for learning in accordance with the approved curriculum, add educational value and be appropriately supervised.
4	TTD 6.1	Doctors in training must be given adequate time to complete the trust induction. Local induction in all specialties must cover how posts fit within the programme, duties and reporting arrangements, roles within the team and departmental policies.

5	TTD 1.4	Doctors in training must receive training in consent to ensure they understand the appropriate intervention and its risks, and are prepared to answer associated questions the patient may ask. This training must be monitored to ensure it is taking place before the consent is taken.
6	TTD 8.4 TD 162	Clinical and educational supervisors in all departments must have an adequate allocation of time in their job plans for training.

Requirement 1: Consultants must oversee handover and this must be scheduled in a way that ensures patient safety and continuity.

1 Handovers where variable between specialties. All doctors in training and medical students we spoke to said that handover in the emergency medicine department was good, formal and always led by a consultant and the lead nurse. Doctors in training reported that handover in acute medicine was particularly poor with the exercise being used to swap bleepers rather than to complete a formal handover. It was reported that the IT department had started filming the handovers to review the footage and recommend changes to make it more effective, and electronic handover will be fully rolled out (it is already working as part of Hospital at Night, which is working well). However, doctors in training and medical students said that they feel the quality of handovers at the time of the visit posed a risk to patient safety and continuity. Consultants should have oversight of all handovers to ensure oversight and to maximise learning opportunities for others. These should be consistent between specialties. It was reported that handovers are done at the end of a shift which means that doctors in training are staying late in order to provide a safe handover.

Requirement 2: Terminology used to refer to and identify doctors in training must be such that patients and colleagues are aware of the status and training grade of each individual. The term SHO must not be used.

2 Out of date terminology is embedded in the Trust. The use of 'senior house' officer is widespread. An SHO may range from F2 to CT2; the difference in competence between these levels means that doctors in training could be asked to do something outside of their competence.

3 Some doctors in training displayed badges that stated 'specialty registrar' at CT1 level. This term is commonly understood to refer to doctors in higher levels of training who have completed core or early stages and this therefore can be misleading to patients and colleagues. Risk of more junior doctors in training being asked to undertake tasks beyond their competence can increase.

4 Doctors in training said that they felt uncomfortable using the title 'specialty registrar' and had spoken to the Trust, but badges had not been amended at the time of the visit and they were not aware of initiatives to drive this forward.

Requirement 3: Working patterns and intensity of work by day and by night must be appropriate for learning in accordance with the approved curriculum, add educational value and be appropriately supervised

5 Workload intensity in some areas- notably acute medicine, surgery and O&G- is preventing trainees from accessing learning opportunities. We heard from doctors in training that they may come into the hospital during their time off in order to maximise the learning opportunities available.

6 We also heard from doctors in training that in General Surgery and Medicine they regularly work additional hours to finish jobs and ensure patient safety is not compromised.

Requirement 4: Doctors in training must be given adequate time to complete the trust induction. Local induction in all specialties must cover how posts fit within the programme, duties and reporting arrangements, roles within the team and departmental policies

7 We heard from doctors in training and medical students that induction varied in different specialties. We heard from clinical and educational supervisors that the trust induction is available electronically and medical students and doctors in training are required to complete this before their first shift. Doctors in training said that this means they have to put their own time aside to do this, and as it was not compulsory it was not always completed before a first shift.

8 It was reported that the induction in emergency medicine and obstetrics and gynaecology was particularly good and if working a night shift, a locum would cover this until induction was completed. We also heard from medical students and doctors in training that local induction varies according to the specialties. In some areas it was as little as an hour's discussion before having to provide tertiary services.

Requirement 5: Doctors in training must receive training in consent to ensure they understand the appropriate intervention and its risks, and are prepared to answer associated questions the patient may ask. This training must be monitored to ensure it is taking place before the consent is taken.

9 FY1 doctors in training in surgical posts reported taking consent for procedures such as stenting, colonoscopy, ERCP, and PICC. They may not have full training for each of these procedures and they reported being uncomfortable with the arrangement.

10 The Trust has a training package aimed at consent, which they shared after this issue was raised as a concern on a visit. Information gathered during the visit indicated

that this package may not have been used consistently and appropriately. Audit and monitoring will be taking place to ensure it is in the future.

Requirement 6: Clinical and educational supervisors in all departments must have an adequate allocation of time in their job plans for training

11 We heard from clinical and educational supervisors that they do not have enough time to dedicate to their educational role due to service pressures.

12 Doctors in training also said that much of their time is spent being used as service provision rather than for educational purposes. We heard a lack of recognition for education in terms of time allocated to training and educating medical students and doctors in training.

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	TTD 5.20	Ensure that feedback to doctors in training is balanced and constructive. This should include both positive and negative comments.

Recommendation 1: Ensure that feedback to doctors in training is balanced and constructive. This should include both positive and negative comments.

13 We heard from doctors in training that much of the feedback they receive has a negative orientation.

14 It is particularly important for feedback to be balanced and constructive with both negative and positive comments in order to develop trainees and learn from negative incidents.

Acknowledgement

We would like to thank the Sheffield Teaching Hospitals NHS Foundation Trust and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.