

## Visit Report on Southampton General Hospital

This visit is part of our regional review of undergraduate and postgraduate medical education and training in Wessex.

Our visits check that organisations are complying with the standards and requirements as set out in [Promoting Excellence: Standards for medical education and training](#). This visit is part of a national review and uses a risk-based approach. For more information on this approach see <http://www.gmc-uk.org/education/13707.asp>

<b>Education provider</b>	University Hospital Southampton NHS Foundation Trust
<b>Sites visited</b>	Southampton General Hospital
<b>Programmes</b>	Undergraduate: University of Southampton, Faculty of Medicine – Years 3-5.  Postgraduate: foundation, core psychiatry, core medicine, general practice, acute internal medicine, psychiatry, child and adolescent psychiatry
<b>Date of visit</b>	6 February 2018
<b>Were any serious concerns identified?</b>	No serious concerns were found on this visit.

### Findings

The findings below reflect evidence gathered in advance of and during our visit, mapped to our standards.

Please note that not every requirement within *Promoting Excellence* is addressed within this report. We report on 'exceptions', e.g. where things are working particularly well or where there is a risk that standards may not be met.

## 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. These should be shared with others and/or developed further.

Number	Theme	Good practice
1	Theme 1 (R1.17)	The trust actively promotes multi-professional learning, which is valued by learners. Nurses and allied health professionals play an important role in the clinical support and education of junior doctors.

### **Area of good practice one: We found evidence of multiprofessional learning. Nurses and allied health professionals play an important role in the clinical support and education of junior doctors.**

- 1** The trust promotes a culture of learning and collaboration between specialties and professions, and supports learners to be effective members of multiprofessional teams. Throughout our visit, we heard numerous examples of multiprofessional learning. Undergraduate students take part in education sessions led by nurses and health visitors, shadow midwives to observe a birthing experience, and also have an interactive session on bullying and undermining in the workplace with nurses as part of their induction programme. In the Emergency Department, students learn alongside nurses and paramedics and have exposure to multi professional team meetings.
- 2** Before starting clinical placement, undergraduate students are required to complete four eight-hour shifts as a health care assistant in their second year. This is very well received, as it allows exposure to the role of other professions on the ward, as well as affording the opportunity to work as part of a multi-disciplinary team.
- 3** The whole multi-disciplinary team take part in providing learners with feedback on their performance using team assessment of behaviour and college based multi-source feedback forms, with supervisors providing support to help learners interpret the feedback and forming an action plan to address any issues raised.
- 4** Doctors training in acute internal medicine complete mandatory training with advanced nurse practitioners (ANPs). We were told they work closely together on the wards, and would like to take part in more training together to encourage cohesion. We also heard that multi-specialty training across different trusts offered by HEE Wessex is valued by the supervisors who attend.
- 5** The trust recognises the importance of the multiprofessional team working together to deliver care when managing the workforce. The out of hours (OOH) service has been difficult for doctors in training due to recent winter service pressures. The senior

management team are planning multiprofessional solutions to these challenges including having a dedicated consultant working on OOH services, more ANPs in medicine, doctors' administrators and an acute care fellow.

- 6 The role of nurses and allied health professionals in the clinical support and education of junior doctors is valued by all groups that we met with. We heard particular praise for the critical care outreach team and overnight phlebotomists, and the OOH ANP's received praise for the support they offer on difficult shifts, their clinical and administrative knowledge base and their helpful attitude.
- 7 Evidence submitted before our visit supported what we heard on the day, including that the OOH service model has led to measurable improvements such as greater staff retention. The visiting team were impressed with the trust's critical care outreach team and overnight phlebotomists.
- 8 Overall, we found that the trust values the importance of multiprofessional working and learning to ensure a collaborative and synergised approach to patient care. The trust enhances the quality of education for doctors in training by promoting a culture of learning and collaboration between specialties and professions and therefore we have identified this as an area of good practice.

### Areas that are working well

We note areas where we have found that not only our standards are met, but they are well embedded in the organisation.

Number	Theme	Areas that are working well
1	Theme 1 (S1.2)	There is an organisational culture that identifies and values the importance of education and training.
2	Theme 2 (R2.2)	Trainees and trainers are well supported as clinicians and educators in the trust. Senior members of the organisation are visible, identifiable and approachable by all grades.
3	Theme 3 (R3.2)	The trust is exploring new strategies to support the working lives of trainees. We encourage the trust to continue to work with trainees on these developments and to monitor their impact.
4	Theme 4 (S4.2)	Middle and senior grade doctors are supported in their development as educators and their contributions to the learning of more junior

		learners (including medical students) are highly valued.
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**Area working well one: There is an organisational culture that identifies and values the importance of education and training.**

- 1** We found that the learning environment and organisational culture values and supports education and training. As a teaching hospital, we heard from the senior management team the importance of education and the culture of improvement at the trust. The trust values the quality visits from Health Education England Wessex (HEE Wessex) and uses them as opportunities to improve. The trust has an excellent working relationship with HEE Wessex, and praised HEE Wessex for being responsive to their concerns. The doctors in training, educational and clinical supervisors reiterated the importance and value of education at the trust. There is time available for education and the trust places importance on allowing trainees to attend teaching sessions.
- 2** Undergraduate students feel they have sufficient learning opportunities at the trust and good working relationships with their supervisors. They added that their supervisors are approachable and enthusiastic to teach. The trust has an awareness of which students are arriving and when. We heard that teaching, whether bed side, nurse-led or lecture-based, is scheduled and regular.
- 3** Doctors in training spoke highly of the quality of education available at the trust. Most departments have protected local teaching days. In particular, we heard that neurology holds specific clinics with consultants and core medical trainees, which core medical trainees lead, allowing them to receive feedback on their work directly. Teaching for all core medical trainees takes place on the same day each month; trainees told us that consultants are aware of this and that their attendance at teaching is protected. Doctors in training have separate clinical and educational supervisors, and both are accessible and available. All doctors in training we spoke with are able to take leave, including study leave. Doctors in training felt that, generally, there are adequate learning opportunities to meet curriculum requirements, although it was noted that chest drains in core medical training can sometimes pose difficulty.
- 4** It's clear that the trust values the importance of education and training to ensure that the future workforce is equipped with the skills needed to treat a diverse and ageing population. All of the trainees that we met spoke highly of the supervision they receive, the quality of teaching provided and the abundance of learning opportunities available at the trust. We have therefore identified the trust's learning environment and culture as an area that is working well.

**Area working well two: Trainees and trainers are well supported as clinicians and educators in the trust. We heard that senior members of the organisation were visible, identifiable and approachable by all grades.**

**5** Both the doctors in training and the clinical supervisors that we spoke to generally felt well supported in their roles as clinicians and educators. We heard throughout the visit of various ways that the trainees and trainers are well supported:

- **Feedback** - the trainees that we spoke to mostly felt listened to within the trust; and we heard that the trust acts on their feedback, and makes changes based on this.
- **Raising concerns** – doctors in training told us they use Safeguard, a clear electronic system for incident reporting, and that they are encouraged by consultants to report patient safety incidents. This was supported by the senior management team who told us that there are formal reporting pathways for trainees to take, such as raising a concern with their consultant or reporting it through Safeguard. Concerns are also raised informally; trainees will email the Chief Executive Officer directly to raise concerns. Additionally, we heard that the Director of Medical Education investigates concerns that are raised via Safeguard and is receptive and reactive to concerns. Clinical supervisors were also positive about the support they receive at the trust and told us they feel comfortable raising any issues with the Programme Director.
- **Educational governance** - we found well-structured governance systems in place, with clear lines of reporting to the trust board. The trust reports on postgraduate medical education quality issues to the board each quarter. Prepared by the DME and the Medical Workforce manager, the trust demonstrates insight into the connection between workforce issues and education and training concerns by reporting jointly on these two areas. We heard that reporting in this manner has allowed the trust to change workforce strategies and staffing models to address issues affecting both patient and trainee experience, and provides evidence to intervene and invest more confidently.
- **Senior management** - senior members of the organisation are visible, identifiable and approachable by all grades. Doctors training in acute internal medicine explained that senior members of staff visit the wards, including the Medical Director, who was visible during the peak winter period.
- **Flexible training** - doctors in training told us of various ways that the trust supports them in their role as clinicians; from receiving full year rotas in advance for less than full time trainees, to being supported by the occupational health team on a phased return to work, we heard of a positive and supported work culture.

- **Sharing best practice** –educators are supported to work together; there is a trust education event which acts as a forum for sharing information, and an acute care module which holds regular meetings to discuss how content is delivered across specialties across the region. We also heard from supervisors that the trust encourages doctors in training to complete continued professional development in order to support them in their role as educators.

**6** To summarise, we observed an organisation with effective governance systems and strong, visible leadership that collectively work together to support trainees and trainers in their clinical duties and as educators within the trust. It's clear that the trust values the importance of ensuring concerns are acted upon and best practice is shared to ensure that staff are supported and ultimately that patients receive safe care.

**Area working well three: The trust is exploring new strategies to support the working lives of trainees. We encourage the trust to continue to work with trainees on these developments and to monitor their impact.**

**7** The trust provided evidence that they aim to enhance well-being for doctors. Induction material and evidence-based support leaflets encourage frequent breaks and advocate taking 'naps' whilst completing nightshifts in the interest of doctor and patient safety. All groups that we spoke with are aware of work done by the trust to support the working lives of doctors in training, including the stress and well-being course 'Keep Calm' which offers tools for the trainees to use in high pressure situations.

**8** We heard from core medical trainees, doctors in higher training in acute internal medicine and general practice of some of the pressures they face every day, particularly when they are short staffed. Trainees are aware of the work the trust has completed to support their wellbeing, however, none of the trainees that we met have been able to put the hospital's well-being policies into practice. It was mentioned that the doctors' common room and the sofas and canteen style chairs in the emergency department are not conducive to restful sleep; trainees told us that they have requested more suitable areas to sleep whilst on call. The trust's efforts to explore new strategies to support the working lives of trainees are commendable. We encourage the trust to continue to work with trainees on these developments, and to monitor their impact.

**Area working well four: Middle and senior grade doctors are supported in their development as educators and that their contributions to the learning of junior clinicians (including medical students) are highly valued.**

**9** The trust has been able to provide financial support for doctors in training undertaking activities which enhance both their training and their development as educators, such as financial aid for Masters Programmes and attendance at conferences to present their work.

- 10** We heard throughout our visit that more junior trainees valued the support and guidance from middle and senior grade doctors. Feedback from undergraduate students on their placements often praises individual doctors in training by name for their support. Core medical trainees spoke of a positive and supportive working relationship with the higher trainees. We also heard of a new way of working in obstetrics and gynaecology (O&G) where every medical student has a specialty registrar mentor who has received mentorship training from the clinical lead. We heard that this way of working may be rolled out to other departments due to the success of the mentor scheme within O&G.
- 11** The importance the trust places on education was evident throughout our visit. By supporting professional development, the trust empowers middle and senior grade doctors in their education. We have therefore identified the trust's ethos and approach to supporting the professional development of middle and senior grade doctors as an area that is working well in the trust.

## Requirements

We set requirements where we have found that our standards are not being met. Each requirement is:

- targeted
- outlines which part of the standard is not being met
- mapped to evidence gathered during the visit.

We will monitor each organisation's response and will expect evidence that progress is being made.

Number	Theme	Requirements
1	Theme 1 (R1.6)	The trust must ensure there is a clear escalation process for trainees to seek support during out of hours work.
2	Theme 1 (R1.14)	The trust must ensure that handover provides continuity of care and maximise learning opportunities for doctors in training.
3	Theme 2 (R2.10, R4.2)	The trust should develop clear and transparent systems to monitor how educational resources are allocated and used. This should include how time committed to education is included in consultant job plans.

**Requirement one: The trust must ensure there is a clear escalation process for trainees to seek support during out of hours work.**

- 12** During our visit we found a lack of clarity amongst trainees with regards to escalation processes in out of hours (OOH) work to obtain senior support. The thresholds for seeking support are unclear to trainees and we have therefore set a requirement for the trust to address.
- 13** We're aware that our visit came amidst the winter pressures which added to the workload of the trust, and has exacerbated the role of those involved in OOH cover. We heard from all doctors in training about the impact of rota gaps, which had increased over the few months prior to our visit, particularly for doctors in higher training. As well as rota gaps impacting on support provided OOH, we also heard that educational supervision has been effected, meaning that it's difficult for trainees to meet with their supervisors on a regular basis. Doctors training in medicine told us of the pressure they had been under during OOH service to cover gaps in the rotas and that one person is often taking on the role of two people.
- 14** We heard that it is doctors in higher training who are mostly affected by the OOH rota gaps. Frequently, the higher trainees take on the roles of two people due to rota gaps, and sometimes take on three. This can happen for a sustained period of time as the rota is structured to pair trainees together, therefore the trainees can be paired with a gap if that post isn't filled. Trainees told us they have raised the OOH rota gaps as a concern via Safeguard but have not received an update on how the situation is being addressed. It is concerning that there is no de-briefing session held after the shifts when a trainee has to cover the role of three people. We also heard that foundation doctors are acting up in the absence of core trainees during OOH.
- 15** In these instances, we found a lack of clarity amongst trainees with regard to escalation processes. We heard variability in whether doctors in higher training or consultants stay beyond their shift to help with the workload, and when doctors are required to contact senior colleagues on call. We found that the decision on whether the workload is unsafe is currently left to the discretion and judgement of trainees from ST3 upwards. This resulted in variable decision making and anxiety amongst trainees as to whether to call for assistance.
- 16** Doctors in higher training also spoke of their unease and discomfort that the onus is on foundation level doctors acting up to raise concerns during their shift. We also heard that it is not always escalated to nursing staff when there is a gap in the rota.
- 17** Overall, we found that the process for on call senior support needs improvement and clarification to reduce variability, to support trainees better and ensure patients are receiving the highest and safest standard of care. The trust must make sure that learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes. The Trust must ensure

consistency and clarity for all staff with regards to an escalation process for OOH senior cover.

**Requirement two: The trust must ensure that handover provides continuity of care and maximise learning opportunities for doctors in training.**

- 18** The trust has implemented the Doctor's Worklist software that utilises a traffic light system in the handover of information. The software aims to improve the efficiency of handover by preventing unnecessary discussion of stable patients, allowing more time to focus on complex cases.
- 19** We found mixed reports from the groups of trainees we spoke to about handover. Some trainees noted that handover happens six times within a 24 hour period, and highlighted the consistency of care this offers. Some spoke highly of the Doctors Worklist software, and in particular praised the function that allows doctors to set tasks to be completed for patients, which are then triaged by OOH nursing practitioners.
- 20** However, it was noted from doctors training in acute internal medicine and core medicine that the morning handover can be one of the most variable in quality due to a 30 minute rota gap between shifts. In this instance, it is the responsibility of the registrar finishing their night shift to find a colleague to hand over high risk patients. Additionally, doctors in training are not aware of a consistent formal handover process between the mental health trusts in the region, though most noted there is usually a phone call and the standard electronic discharge summary is sent to the mental health unit. We also heard that there is a 'hospital passport' from patients that have been in Bluebird House, a secure mental health inpatient unit, to outline their needs.
- 21** We understand that safe and efficient handover is a service priority for the trust, with good practice being shared between clinical areas. For example, medicine is in the process of mirroring a surgical style handover, which has been identified as working well. However, the visit team are concerned that variability in handover, particularly the timing of the morning medical handover, poses a risk to continuity of care for patients and learning opportunities for doctors in training.

**Requirement three: The trust must develop clear and transparent systems to monitor how educational resources are allocated and used. This should include how time committed to education is included in consultant job plans.**

- 22** We heard that the trust is working through a number of challenges in the delivery of undergraduate education. The trust has suffered from a significant loss of income due to changes in the service increment for teaching funding for undergraduate placements from Southampton Medical School. The trust told us that understanding the new funding system has been a substantial piece of work, undertaken in partnership with Southampton medical school. The trust also acknowledged the difficulty in delivering education alongside current service pressures, including

competing priorities for consultants' supporting professional activities (SPA) time. We also heard there are considerable challenges to delivering Southampton medical school's new curriculum, including the impact of hosting large numbers of students, and the reality of fitting the curriculum against the modern day NHS service, when consultants work different shift patterns and therefore may not be able to offer consistency for students on placement.

- 23** The trust has a large number of consultant staff. As a teaching hospital, all consultants are expected to deliver training and education to both undergraduate and postgraduate learners. In our meeting with education management, we heard that SPA time is being used to allocate time for teaching and education.
- 24** SPA time is allocated across the trust using different models in different departments. At our visit, we heard mixed reports of whether those involved in delivering education have the time to do so. In particular, we heard that undergraduate education is being delivered by people who do not have adequate time in their job plans, and it is reliant on the good will of those involved.
- 25** Whilst it is not uniform across the trust, we heard that time for education has improved in divisional budgets; in 2018 the trust plans to make sure that educational income is visible in care group budgets to enable better transparency and reduce discrepancies in educational activity and income. We support the trust's work in clarifying the scope and volume of undergraduate educator activity.
- 26** However, we remain concerned that the lack of time in job plans poses a risk to educators in their ability to carry out their role in a way that promotes both safe and effective care and a positive learning experience for trainees. We have therefore set a requirement for the trust to develop clear and transparent systems to monitor how educational resources are allocated and used.

## Recommendations

We set recommendations where we have found areas for improvement related to our standards. They highlight areas an organisation should address to improve, in line with best practice.

Number	Theme	Recommendations
1	Theme 1, 5 (R1.13, R5.4, R5.9)	The trust should review the structure for local induction for both postgraduate and undergraduate learners.
2	Theme 1 (R1.19)	The trust should ensure that all trainees should have access to trust computers and Wi-Fi.
3	Theme 3 & 4 (R3.7, R4.4)	The trust should review the administrative

**Recommendation one: The trust should review the structure for local induction for both postgraduate and undergraduate learners.**

- 27** The trust faces some challenges with delivering induction, mostly associated with the high volume of undergraduate students and postgraduate learners arriving throughout the year for varying lengths of time. As a result, the trust has developed an online welcome and introduction to the trust as a whole. A corporate induction for postgraduate doctors is also held once a month, where doctors meet the DME, are welcomed to the trust and told how to raise concerns.
- 28** All learners, undergraduate and postgraduate, have a local induction for each placement and rotation. This induction should clearly set out their duties and supervision arrangements, their role in the team, how to gain support from senior colleagues, the clinical or medical guidelines and workplace policies, and how to access clinical and learning resources. Whilst foundation doctors told us they value their induction at the start of the programme as it introduces them to internal processes and their colleagues, we heard from other doctors in training that local induction can be variable in quality. In particular, the induction in the acute medical unit did not prepare doctors in training for their workload, and some core medical trainees and foundation doctors didn't receive an induction for this part of their rotation.
- 29** Whilst some local inductions are helpful as they cover key colleagues to contact, ward cover and the hospital at night structure, doctors in training told us that key practical information, such as how to use the doctor's worklist handover software, wasn't covered. This is essential to include, as they are required to interact with it on the first day of their placement to find out which patients they're looking after.
- 30** We remain concerned about the variability in local induction across specialties. Whilst no specific patient safety concerns were reported during our visit, we are concerned that doctors in training may start a rotation without receiving an adequate induction to local processes and procedures, which can impact on patient safety. We have therefore set a recommendation for the trust to address.

**Recommendation two: The trust should ensure that all trainees have access to trust computers and Wi-Fi.**

- 31** Organisations must have the resources and facilities to deliver safe and relevant learning opportunities required by the relevant curriculum and training programme. This includes adequate internet access so that learners can access online curricula. On our visit, we heard from both undergraduate students and postgraduate trainees that they are unable to access hospital Wi-Fi whilst on the wards. Students told us that they have to complete online assessments, but to do so they must leave the clinical environment and log on to the Wi-Fi in the education centre. It was noted that

whilst restricted access to digital resources has not prevented learners from meeting their curriculum and training requirements, it has posed a difficulty.

- 32** We understand that the digital agenda is a trust priority, and there is currently investment in many projects aimed at improving clinical care and efficiency for staff. This includes a bespoke clinical system known as 'Charts' as the trust moves to a complete electronic medical record system. We were pleased that students have recently been granted read-only access in recognition of their need to view records as part of the clinical team when on placement. However, at the visit we heard that some students do not have the necessary log-on details to access the trust's computers.
- 33** We acknowledge that there is working internet access in some areas of the trust, such as the education centre, but we encourage the trust to ensure that medical students and trainees have access to Wi-Fi in the clinical environment. It was unclear to trainees whether they were able to access the trust Wi-Fi network. Undergraduate and postgraduate trainees require access to Wi-Fi to support their practice and learning. We encourage the trust to review computer and Wi-Fi access for all learners.

**Recommendation three: The trust should review the administrative support allocated to education within the trust.**

- 34** The trust's service structure forms four service divisions, each with its own DME, overseen by the trust's overarching DME. Each service division is the size of a small district general hospital. We heard praise for the work of the trust's DME and team, and also heard of the value the trust sees in having divisional DMEs based in the clinical areas which they are responsible for; allowing them to support the clinical teams and address issues at a local level.
- 35** However, we found a lack of clarity across trainees, trainers and senior educators about the organisation and delivery of support to medical education processes. We found that this was unclear most notably in undergraduate training. For example, we heard that the coordination and facilitation of undergraduate placements at the trust was variable. Students told us there is inconsistency in the amount of information they receive in advance of their placement, depending on the placement and module they are on. We also heard that undergraduate students are not clear on who they would raise patient safety or educational concerns with whilst on placement, with apprehension that raising a concern may have consequences on their clinical skills sign-off.
- 36** Undergraduate educators told us that the management of undergraduate and postgraduate education is merged at the trust. They added that whilst this has some benefits, it is not clear who holds the responsibility for the administration of undergraduate education. We heard that this can impact on the organisation of student placements.

**37** Whilst we found that the postgraduate administrative support works well, we remain concerned that at an undergraduate level learners are not receiving timely information about their clinical placements and educators require more support in dealing with their undergraduate educational responsibilities. Effective administration supports teaching and can enhance the experience for trainees, trainers, educators and will ultimately impact on patient care. As such, we recommend that the trust should review the administrative support allocated to education within the trust.

<b>Team leader</b>	Professor Simon Carley
<b>Visitors</b>	Dr Ann Boyle, Dr Jenny Armer, Dr John Jones, Dr Katie Kemp
<b>GMC staff</b>	Jessica Ormshaw, Lindsay Bradley
<b>Evidence base</b>	The trust prepared a lengthy document submission in line with our guidance. The documentation submitted was used to inform our visit and a full list is available on request.

## Acknowledgement

We would like to thank Southampton General Hospital and all those we met with during the visits for their cooperation and willingness to share their learning and experiences.