Good Medical Practice

- “Teaching, training, appraising and assessing doctors and students are important for the care of patients now and in the future. You should be willing to contribute to these activities” Para 15

- “You must make sure that all staff for whom you are responsible, including locums and students are properly supervised” Para 17

- You must be honest and objective when appraising or assessing the performance of colleagues, including locums and students. Patients will be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.” Para 18

General Medical Council, 2006, updated 2009

Safety

Domain 1 of the General Medical Council’s ‘The Trainee Doctor’ (GMC Feb 2011) is concerned with the essential safeguards on any action by trainee’s that affects the safety and wellbeing of patients. The first standard within this domain states, ‘The responsibilities, related duties, working hours and supervision of trainees must be consistent with the delivery of high-quality, safe patient care.’

Supervision

There are five different types of ‘doctor in training’ working with Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW):

1. **Foundation Programme doctors** - These doctors are in their first or second year of generic post-graduate training. Their learning is guided by the Foundation Programme Curriculum and their training is managed by the Foundation Programme Training School. They are relatively inexperienced and need a greater degree of direct supervision than other doctors in training grades

2. **General Practice Training Scheme doctors** - These doctors have completed the Foundation Training Programme and have decided to pursue Specialty Training to become General Practitioners. Part of this training entails six month placements in hospital posts, including psychiatry. Their learning is guided by the GP Specialty Training Curriculum and their training is managed by the Postgraduate School of General Practice. They are more experienced than Foundation Programme doctors, but have usually not done psychiatry before coming to the Trust; therefore they also need a significant amount of direct clinical supervision.
3. **Psychiatry Specialty Trainees**, who will either be in Core Psychiatry Training (CPT) or one of six advanced psychiatry training programmes that lead to a Certificate in Specialty Training (CST) in one of the psychiatry specialties. Their learning is guided by the relevant psychiatry specialty curriculum and their training is managed by the School of Postgraduate Psychiatry. CPT consists of a three year programme of hospital placements, therefore CPT trainees’ need for direct clinical supervision may be highly variable.

4. **Paediatric doctors who work in Learning Disability services.** There is always one core paediatric trainee and occasionally there is an advanced paediatric trainee.

5. **Rehabilitation Medicine Specialty Trainees** - These doctors are at ST3 level or above and are in training for a Certificate in Specialty Training in Rehabilitation Medicine. Their learning is guided by the Rehabilitation Medicine Specialty Curriculum and their training is managed by the School of Medicine. Their training consists of a four year programme of placements, some within NTW Trust, both inpatient and community services and some outwith NTW. Their out of hours commitments remain with NTW Trust throughout their rotation. Their need for direct clinical supervision is variable depending upon the stage of their training. The trainees in rehabilitation may have an Educational supervisor employed by another trust.

The Trust’s policy, NTW(C)31 - Clinical Supervision and Peer Review’s description of clinical supervision can be equated to the personal/educational supervision that a doctor in training receives from their designated educational supervisor or line manager and to the supervision that the doctor receives in connection with specific elements of clinical practice. Both of these forms of supervision are important to the development of the medical professional and to the maintenance of high standards of patient care. They are both prescribed in the relevant GMC approved curriculum (both Foundation and Specialty Training).

Doctors in training also have a Training Programme Director involved in overseeing their professional development, they may also have input from an Educational Tutor and/or a College Tutor. These roles are different and complimentary; they are described in the relevant role description. They are not, however, involved in the day-to-day line management or supervision of the doctor-in-training.

**Educational Supervision**

The purpose of educational supervision is to oversee the education, training and development of learners by a process of managed learning, support and validation (Postgraduate Institute for Medicine and Dentistry, University of Newcastle, 2002)

**Role of the Educational Supervisor**

An Educational Supervisor/tutor is a Consultant, Senior Lecturer or Professor who has been appointed to a substantive consultant position. They are responsible for the educational supervision of one or more doctors in training who are employed in an approved training programme. The Educational Supervisor will require specific experience and training for the role. Educational Supervisors will work with a small
(no more than five) number of trainees. In most situations within the Trust, the Educational Supervisor will also be the clinical supervisor/trainer. Educational Supervisors must have completed a recognised programme of initial training for being an Educational Supervisor; be in good standing for Continuing Professional Development, and they should attend training events and updates organised for the local faculty of postgraduate medical education. Their annual appraisal must include an appraisal of their work as educational supervisor.

All trainees will have an Educational Supervisor whose name will be notified to the trainee.

The Educational Supervisor acts as the trainee’s line manager. Educational Supervisors work closely with other members of the local faculty of postgraduate medical education, including clinical supervisors, College Tutors, the Postgraduate Deanery-appointed Programme Director, the Clinical Director of Post Graduate education and the Deputy Medical Director (Performance)

**Duties of the Educational Supervisor**

The duties of the Educational Supervisor can be divided into four categories:

**1 – Induction**

Within the first week of a trainee starting in a post, the Educational Supervisor (or nominated deputy) must meet with the trainee to complete the following: -

- Confirmation of the duties of the post
- A review of the trainee’s logbook/learning portfolio and self-assessment
- A statement regarding the degree of supervision required when undertaking specific professional duties
- An individual learning plan (ILP)
- A signed Learning Agreement

**2 – Coaching**

The educational supervisor will hold a documented one-hour meeting with the trainee per week. This is regarded as a minimum; there can be other ad hoc meetings. The fixed “one-hour per week” meeting is focussed on the trainee doctor’s personal learning and development needs and its purpose is to ensure that the trainee makes use of the opportunities available to fulfil the requirements of the relevant curriculum.

**This will include:** -

- Regular review of the trainee’s ILP to ensure that it remains relevant and that the trainee is making progress towards their learning objectives
- Encouraging reflective practice
- Assisting the trainee to identify suitable opportunities for workplace-based learning and assessment
- Responding appropriately to evidence of under-performance in the trainee
3 – Appraising

It is important that trainees have regular feedback on their performance. Educational supervisors will as a minimum: -

- Appraise the trainee’s performance at the mid-point and at the end of the post

4 – Assessing

Educational supervisors will contribute to the assessment of the trainee as required by the relevant curriculum and training programme, this will include: -

- Completing workplace-based assessments, including multi-source feedback instruments, on the trainee as appropriate
- Helping the trainee identify other members of the multi-disciplinary team who will contribute to their performance assessment
- Providing an assessment of the trainee for the trainee’s educational appraisal and annual review of progress

Further information about the specific tasks of educational supervisors can be found in the relevant GMC approved specialty curriculum.

Clinical Supervision

The GMC document ‘The Trainee Doctor’ (GMC, 2011) includes the following:

**Standard 1.2**, “Trainees must be appropriately supervised according to their experience and competence, and must only undertake appropriate tasks in which they are competent or are learning to be competent, and with adequate supervision. Trainees must never be put in a situation where they are asked to work beyond the limits of their competence without appropriate support and supervision from a clinical"

**Standard 1.3**, “Those supervising the clinical care provided by trainees must be clearly identified; be competent to supervise; and be accessible and approachable at all times while the trainee is on duty.”

Good clinical supervision must therefore be available to trainees in the course of routine and emergency work. Their Educational Supervisor will provide much of the trainee’s clinical supervision, but other clinicians will deliver the clinical supervision of some aspects, especially out of hours work and some specialist work, such as psychotherapy. It is an important part of the training of advanced trainees that they have experience in supervising those less experienced, but for this to be most valuable; the advanced trainee must have opportunity to practice this with feedback from senior colleagues. There must be clarity about who is supervising which element of a trainee’s work. This is particularly important for out of hours work and in urgent situations.

When a trainee receives clinical supervision the name of the clinician giving advice and the substance of the advice must be recorded in the patient’s clinical record.
Supervision of Routine Work

This should include:

1. The presence of the Consultant and/or supervising middle-grade doctor at ward round/team meeting

2. Easy access to the Consultant and/or supervising middle-grade doctor through the working week to discuss points of diagnosis, treatment, risk assessment or management.

3. It is good practice to have one or more “mini reviews” in addition to the weekly team meeting

4. New out-patients seen by Foundation Programme, General Practice and Core Psychiatry trainees should be supervised “live” by the consultant/supervising middle-grade doctor. This need for live supervision reflects the relative inexperience of junior trainees and complexity of new patient assessments referred into secondary services. This practice should be adapted according to the supervisor’s assessment of the trainees’ competence, it may range from the whole assessment being done jointly with the supervisor to the supervisor joining at the end of the assessment or arranging to see the patient at a later date as part of an extended assessment. If a core trainee has successfully gained their MRCPsych or has completed a years training in the speciality they are working in the supervising consultant can assess the need for this live supervision. If following this assessment they feel the trainee is competent to complete a specialist assessment and recognise the limitations of their competence then they will record this and the trainee can assess patients in this speciality with non-live supervision.

5. The trainee’s educational supervisor/line manager should regularly review the trainee’s out-patient case load for size, complexity, appropriateness of management, and need for transfer of cases to a more senior person. It is recommended that this should occur on at least two occasions over the trainee’s placement; so during a six month period, it should take place at two and four months.

6. In circumstances where care coordinated patients remain in a trainee (excluding higher trainees or speciality doctors) clinic for over six months there should be a “live” review of the patient with the trainee and supervisor.

7. In addition to this, the trainee must have regular opportunities to discuss problems with out-patients with the relevant consultant.

8. Psychotherapy case work must be appropriately supervised and time will be allocated for this

9. Foundation year one doctors are particularly inexperienced and additional measures must be in place to provide closer supervision. F1 doctors should not make any independent decisions regarding prescribing or broader patient management (this is relevant for both mental health and physical health problems)
Supervision of out of hours work

It is essential to ensure quality of service and safety of the patient, and indeed for the protection of trainees and trainers, that out of hours work is properly supervised. All grades of doctor’s on-call for the Trust share the following roles/responsibilities with varying degrees of emphasis depending on their degree of competence and their level in the on-call team:

- Responsibility to ensure safety and the smooth running of the service
- Responsibility to maintain an awareness of the work, which is being undertaken by the on-call team during a period of duty and to supervise/support colleagues as appropriate to grade
- Responsibility for the co-ordination of work, including contributing where appropriate and arranging the handover of patient care to other parts of the service

These 3 responsibilities are interlinked; for example, in order to ensure the smooth running of the service, it is clear that work will have to be co-ordinated, and for this to be achieved, on-call doctors need to have an up-to-date awareness of the workload facing the team.

In order to facilitate this system, it is useful to clarify the expectations falling on the on-call team regarding (i) supervision, (ii) maintaining contact and being aware of the workload between the on-call levels and (iii) when it would be appropriate for a doctor to ask a more senior colleague to assist in performing work.

1. Supervision

All trainees who have less than one year’s experience of psychiatry (i.e. all Foundation Programme doctors, paediatric trainees, GP trainees and year one Core Psychiatry trainees) must discuss all assessments they have conducted and all mental health care plans or treatments that they initiate or alter with a Specialist Psychiatrist (Consultant/Associate Specialist/Specialist Registrar or equivalent) prior to implementing them.

As a Core Psychiatry trainee approaches the end of their CT1 year, their educational supervisor may judge that the trainee no longer needs to seek such mandatory clinical supervision. This decision will be clearly communicated to the trainee and recorded in the trainee’s portfolio (or equivalent). A Core Psychiatry trainee who receives an outcome 1 from their year one Annual Review of Competence Progression (ARCP) will also no longer needs this mandatory clinical supervision. If the trainee does not receive an ARCP outcome 1, a clear decision will need to be taken by the educational supervisor in consultation with the relevant Training Programme Director regarding the level of clinical supervision that is needed. Other trainees are encouraged to discuss emergency assessments with a Consultant or advanced psychiatry trainee doctor prior to implementing a management plan, particularly in the first month or so of a new placement.
2. Contact between grades

It is expected that there will be regular telephone contact between the different grades of on call staff, whether or not advice/assistance is being sought concerning specific matters.

Week nights: the second on-call should contact the first on-call psychiatrist at least once during a period on-call, suggested arrangements being between 1800 hours and 2200 hours. The consultant (if they are third on-call) should contact the other levels of on-call doctor at least once.

Weekends: contact between the consultant on-call and the other levels of on-call doctor should be made at least once in 24 hours, preferably at the beginning of the period of duty.

3. Quality Issues

As part of a quality out of hours service, it is unreasonable that patients and their carers be kept waiting for long periods after a request for their assessment has been made. It is for each on-call team to decide on arrangements to ensure that assessments are completed in a timely manner.

Each service should consider, for example, whether the second on-call should see patients who would otherwise have to wait for the first on-call to be free, and what the threshold for such involvement should be.