Introduction

This report gives an overview of medical education and training across the East Midlands in 2016, aligned with the themes set out in *Promoting excellence: standards for medical education and training*. The findings originate from our visits to five local education providers (LEPs), two medical schools and the Health Education England (HEE) local office in the region.

Why did we choose the East Midlands?

Our schedule of regional visits outlines our visits of each region and country within the UK over a seven-year period. * We visited the East Midlands in 2016 as part of this schedule.

What do we know about the region?

With respect to undergraduate medical education, there are two medical schools in the East Midlands.

- **Nottingham Medical School** accepted its first cohort of medical students in 1970. In 2013 the University of Nottingham undertook a major restructuring project, resulting in the establishment of the new School of Medicine. There is significant work underway at Nottingham Medical School to develop and implement a new curriculum, with substantial changes to assessment. Before the regional review, we last visited Nottingham Medical School in September 2014 as part of our audit of undergraduate assessment practice across UK medical schools.†

- **Leicester Medical School** was established in 1975, subsequently Leicester partnered with the University of Warwick in 2000 to form the Leicester Warwick Medical School. Warwick applied for separate accreditation from 2007 and the school reverted to its original name. The school was recently refurbished with brand new facilities. Leicester Medical School have also undertaken work to revise their curriculum. The new curriculum began implementation in September 2016. We last visited Leicester Medical School in September 2006, as part of a scheduled visit, to review their assessment.

There were a total of 2,591 medical students in the East Midlands during the 2016–17 academic year.

* Wales, West Midlands, North West and London are not listed as they were visited between 2012 and 2014.
† You can find the report on the way undergraduates are assessed on our website at: [www.gmc-uk.org/education/26836.asp](http://www.gmc-uk.org/education/26836.asp).
Health Education England has responsibility for the quality management of postgraduate medical education and training. At the time of this review, HEE was undergoing significant reorganisation; on 1 September 2016, the 13 local education and training boards (LETBs) in England were assimilated into four LETBs.


There were around 3,013 doctors training in the East Midlands at the time of this review in 2016.

Professor Sheona MacLeod was appointed Postgraduate Dean in the East Midlands in 2012 and was appointed to the role of Chair of English Deans in May 2015.

At the time of our regional review, there were six NHS trusts in the East Midlands subject to our enhanced monitoring process.† This review did not focus on these cases, rather the overarching systems and processes in place across the region, and so we did not visit those departments. They are subject to separate enhanced monitoring visits.

**What did we do?**

To understand the experience of medical students and doctors in training in the East Midlands, we:

- reviewed evidence, such as our national training survey results and reports from HEE EM, on all trusts and specialties and then chose six LEPs to visit. We also took into account intelligence provided by our network of regional liaison and employer liaison advisers and recent reports from the Care Quality Commission.‡

* [https://hee.nhs.uk/hee-your-area/east-midlands](https://hee.nhs.uk/hee-your-area/east-midlands).

† Enhanced monitoring is the process by which we support deaneries and Health Education England local offices to resolve safety and quality issues in medical education and training. Issues subject to enhanced monitoring are those we believe could adversely affect patient safety, doctors' progress in training, or the quality of the training environment.

‡ Our regional liaison advisers work with doctors, patients, medical students and others across England to make sure we understand their needs, and to explain and discuss the work we do. Our employer liaison advisers work with employers across the UK to create closer working relationships with the General Medical Council (GMC).
requested and analysed substantial evidence from five education providers (LEPs), the two medical schools and HEE EM, demonstrating how they meet our standards.

visited all selected organisations between October and December 2016, meeting with students, doctors in training and a range of educators to identify good practice and areas where more work was needed to meet our standards for training.

Our visit teams consist of medical and lay associates with relevant medical and educational expertise, including student and doctor in training representation. Teams also include quality assurance expertise provided by GMC staff.

You can read the detailed reports of the individual site visits on our website at: www.gmc-uk.org/education/26807.asp.

The LEPs we visited were:

- Sherwood Forest Hospitals NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- Circle Nottingham NHS Treatment Centre
- University Hospitals of Leicester NHS Trust
- Kettering General Hospital NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust.

The LEPs visited were chosen using the approach outlined below on the basis of both risk and what is both deliverable and practical. There is no single algorithm for site selection; decisions were based on what cohort of sites would give us the information we needed to carry out the review.

What evidence did we use to establish the focus of our visits?

We survey all doctors in training and trainers across the UK once a year through our national training surveys.* We looked at the results for the East Midlands and how they compare nationally to help us identify areas to explore during the visits.

* You can find out more about our national training surveys on our website at: www.gmc-uk.org/education/surveys.asp.
Other factors used to identify which LEPs to visit and which specialties to focus on during the visits included:

- scrutiny of routine reports, over the last two years, from the medical schools and HEE EM
- previous quality assurance visits we had carried out within the region and any other ongoing quality assurance activity
- numbers of foundation, core and higher specialty doctors training at each site in the selected specialties
- number of medical students located at each site
- the geographical range of LEPs in the region.

During 2016, before our visits, we carried out a survey of medical students from Leicester and Nottingham Medical Schools to learn more about the student experiences at medical school and while on their clinical placements at LEPs. 24% of medical students at Nottingham and 50% of medical students at Leicester responded to the survey.

**Which specialties and stages of training did we focus on?**

Our regional reviews consider several specialties and stages of training in more detail. The evidence set out above informs our decision on which of these to consider.

When selecting programmes we considered three factors.

- Risk, based on our evidence. It is also for this reason that foundation doctors in training and medical students on placements are always interviewed. These individuals are the most junior and least experienced within a training environment and therefore we consider these groups to be the highest risk.

- The frequency on which programmes have been considered by previous GMC reviews. Whenever possible, we made efforts to choose specialties that have not been covered by other reviews to contribute to collection of additional intelligence. But we also based this decision on evidence and risk, so some repetition was unavoidable.

- Whether the issues highlighted through our reporting tools could be solved more effectively via other more targeted channels like enhanced monitoring or local quality management visits.

For this review, we focused on the following training programmes:

- Undergraduate
- Foundation
- Core medical training
- Anaesthetics
- Medicine - acute internal medicine, cardiology and gastroenterology (gastroenterology at University Hospitals of Leicester NHS Trust, Nottingham University Hospitals NHS Trust and United Lincolnshire Hospitals NHS Trust).
- Emergency medicine (at Kettering General Hospital NHS Foundation Trust and Nottingham University Hospitals NHS Trust). *

During the visits, we spoke to medical students, doctors in training, their teachers and supervisors, lay representatives and the senior and quality management teams of each organisation. We also asked each organisation we visited to give us further detailed evidence demonstrating how they meet each requirement in our standards before our visit, to help inform our decisions on areas to explore during the review and decisions taken following visits. This evidence is as important as what we hear on visits when we make our decisions on where our standards are and are not being met.

* Emergency medicine at Sherwood Forest is currently in enhanced monitoring. Emergency medicine at University Hospitals of Leicester was in enhanced monitoring until early 2016 so neither was visited.
What themes did we find in the region?

In postgraduate training, overall, we were impressed with educational governance systems in LEPs across the region.

University Hospitals of Leicester and Kettering General Hospital both have appointed non-executive board members responsible for education. They advocate for improvements in, and accountability for, education at a board level. We also heard elsewhere in the region that good educational governance systems have helped LEPs to address and mitigate the effects of service pressures on education. We were impressed by the awareness and oversight of education and training within senior management at the majority of LEPs we visited.

Addressing common issues across the region

All of the LEPs we visited were dealing with issues around workload, resources and gaps in rotas. Those responsible and accountable for the delivery of medical education locally must take the appropriate steps to make sure the training of doctors remains protected – particularly as medical training is regarded as a bellwether for the quality and safety of patient care. Indeed, this is a focus of our standards for education and training, Promoting excellence and it is encouraging that so many of the LEPs we visited are taking action.

This approach is enabled by HEE EM, which takes a supportive and collaborative approach to quality management in the region. Their quality visits approach was recently redesigned with input from LEPs, to make sure the new system works for all involved in postgraduate education. They also invest time and resources in developing education leadership within LEPs so issues can be picked up, and improvements driven, locally. Directors of medical education (DMEs) at LEPs we visited appreciated the support they receive from HEE EM, particularly from regular regional DME meetings, where issues and solutions are shared, and from the quality team.

Medical schools are changing to improve education they offer

Both medical schools we visited were in a period of transition. Leicester Medical School is implementing a new curriculum which has much more of a primary care focus. The new curriculum gives students earlier patient contact. Nottingham Medical School has recently made changes to their assessment framework; clinical skills assessments will now be at one site, rather than in multiple sites across the region. They are also reducing the number of assessments undertaken throughout the course.

In both medical schools, the changes are designed to improve the learning experience for medical students. However, when we spoke to medical students at both schools it was clear that these changes, and the uncertainty caused by them, were resulting in disquiet.
This underlines the need for an effective communication strategy to support students during periods of change.

We found areas of good practice at each medical school. At Leicester, patient feedback is collated by students and is used to assess their clinical and communication skills. We were also impressed by Leicester's quality management systems, which were effective at identifying risks, driving improvements and highlighting good practice. At Nottingham, we were impressed by the graduate entry and widening participation programmes, both of which offer excellent support to learners. In the graduate entry programme, a peer marking initiative has been introduced where students mark both theirs and others’ work, generating greater insight into how assessments are marked.

**What concerns did we identify?**

We did uncover individual concerns relating to undermining during our visits to three LEPs. These were treated as serious concerns and shared with relevant individuals in those organisations during the visit, as well as with the postgraduate dean at HEE EM. We did not include them in the relevant LEP reports to protect the anonymity of the individuals involved. We were assured that appropriate actions were already being taken locally in these individual cases and added more general requirements for the LEPs to meet where appropriate.

**A positive picture of training and education**

We found that HEE EM's quality structure ensures proportionate quality management across the local area, driving improvements in quality and with a good oversight of potential and new issues and with good support given to directors of medical education. This is important as our quality assurance of medical education and training relies on strong local governance and quality management systems.

We also found both medical schools have good systems in place to make sure they deliver high quality education. As well as positive examples of educational governance, we found that there were generally good systems for reporting and dealing with patient safety concerns in LEPs and that education and training is valued.

**A changing picture**

Finally, it’s important to understand that our reports cover the situation as we found it during our visits between October and December 2016. We are aware that since these visits, the situation has changed. For example, during our visit to Sherwood Forest Hospitals NHS Foundation Trust we heard how the trust was making plans to merge with Nottingham University Hospitals NHS Trust; it has since been confirmed that the merger won’t take place.
Since our visits, Kettering General Hospital NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust have been placed into special measures by the Care Quality Commission. We have reviewed the CQC’s findings alongside ours, and are working with HEE EM to make sure education standards are maintained.

We have also seen LEPs in the region struggling with service pressures since our visits. Our regional review can only be a snapshot of a place in time, but we continue to engage with medical schools and LEPs, via HEE EM, to be assured education and training remain protected.

We reviewed HEE EM’s quality management structure and found that it was working well. Since our visits, Health Education England has begun the process of standardising all quality management across England. This may well mean the processes HEE EM uses in the future will be different to those we observed during this review.

Assessing the region against our standards

The purpose of a regional review is to provide assurance against our standards of how medical education and training is quality managed and quality controlled locally. We have summarised how the organisations we visited are complying with the standards and requirements as set out in Promoting excellence: standards for medical education and training. We have detailed areas that are working well, as well as areas where improvements are needed under each of the five themes in Promoting excellence.
We concluded there was a safe learning environment and culture at all of the LEPs and medical schools we visited.

- We found the culture at trusts generally had positive learning environments for both learners and trainers. Trainers and supervisors are dedicated and committed to their educational roles.

- Education and training is a valued part of the organisational cultures. The learning environment is friendly and supportive.

- Doctors in training are encouraged to report any patient safety concerns they may have, and are confident that issues are dealt with.

**Rotas**

Trusts have aimed to address the issues with rota gaps, in both trainees and consultants, through the creation of non-training grade posts and exploring wider workforce solutions.

Some trusts, such as Nottingham University Hospitals NHS Trust and University Hospitals of Leicester NHS Trust, have used trust grade doctors to fill rotas. Trusts such as Kettering General Hospital NHS Foundation Trust have developed this further – providing bespoke training programmes to facilitate professional development for trust grade doctors and, if appropriate, help them prepare for entry to the specialist register through Article 14.

At Sherwood Forest Hospitals NHS Foundation Trust, nurse educators provide some training, particularly to medical students, reducing the reliance on consultants. We heard how employing and developing trust grade doctors has made a substantial contribution to specialties with difficulties recruiting, such as emergency medicine at Kettering.
However, we heard there is a perception that bespoke training programmes for non-training grade doctors can compete with recognised training programmes for doctors, risking instability in training programmes in the region. Furthermore, non-training grade doctors can regularly move between different, competing, trusts, destabilising rotas.

Consequently, we require HEE EM to work with LEPs to develop a more long-term and sustainable solution to rota gaps across the region.

Case study: Learning patient safety lessons

We were encouraged to hear how HEE EM is proactively trying to share learning across the organisation and identify training environments at risk as soon as possible.

In the school of medicine, HEE EM has appointed a lead for ‘red-flag’ specialties, to share expertise on how to support specialties where there are high levels of concern around training. This lead offers support to the heads of school, trainers and doctors in training and training programme directors. The lead also works closely with the HEE EM quality team, and has contributed to quality visits. The school recognised that, as there are a large number of specialties in medicine, there may not always be the experience within a particular specialty of recognising and helping a training environment in difficulty. The lead’s role is to share experience and good practice across the specialties.

Similarly, we heard from the school of emergency medicine how they used lessons learned from supporting one environment in difficulty to identify another in need of support at an early stage. The school worked with the Emergency Department at Kettering General Hospital NHS Foundation Trust to make sustainable improvements to training there. They then identified another department at risk of having the same issues. This early identification of risk led to an early intervention into the department, at Sherwood Forest Hospitals NHS Foundation Trust – we’re now monitoring progress though our enhanced monitoring process.

We highlighted these initiatives as areas working well in the HEE EM report, and encourage it to continue this approach to identifying risks and sharing lessons.

Handover

During our visits to LEPs across the region, we found that handover arrangements were variable between sites and between specialties. We found some instances of well organised handover arrangements and others where improvements are needed.

At both Pilgrim Hospital and Lincoln County Hospital doctors in training told us they consider handover at the weekend to be inadequate and potentially unsafe for patients.
We heard the current system relies on a paper handover which is passed between work shifts. Educators acknowledged that the current system was weak and told us that the trust is working to develop an electronic handover system.

Similarly at Sherwood Forest, the doctors in training we met perceive the current paper based system to lack continuity of care and to be unsafe. In addition, we were told about sporadic instances in which patients have been missed as they have not been added to the paper based system.

At Kettering, we heard the trust is in the process of introducing an electronic handover system but many of the people we met during the visit referred to a paper based process. Handover takes place in the morning, late afternoon and to the hospital at night team. Consultant presence at handover appeared variable according to time and specialty. On a number of occasions we heard that handover is less structured in the late afternoon and that this had already been identified as an area requiring improvement.

**Case study: Handover pulse check - University Hospitals of Leicester NHS Trust**

The pulse check is a highly praised initiative that is evident in some departments of University Hospitals of Leicester NHS Trust. The pulse check is a catch up meeting that takes place at 3am. This gives doctors in training, consultants and the multiprofessional team a chance to review how work is going in the department. The team discusses how busy the wards are, how work can be distributed where required, and other minor issues occurring on the wards.

Doctors in training said they can miss the pulse check only if there are emergencies. They said they find it useful to take this time to pause and assess the running of the department.

Doctors in training also said the pulse check was an opportunity for the team to eat together which makes it a beneficial, supportive social space as well.

We urge the trust to continue to roll out this initiative across the different departments in the trust due to the reported benefits it brings to the team.
One of the requirements under theme 2 of *Promoting excellence: standards for medical education and training* specifies that organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show it is meeting the standards for the quality of medical education and training within its organisation and responding appropriately to concerns.

- We came across effective systems of educational governance at the medical schools allowing them to identify and quality manage issues.

- At most of the trusts we visited, educational issues appeared to be well-sighted at board level. We found that these trust boards demonstrated strong accountability for educational governance and this has made sure undergraduate and postgraduate education and training are properly considered at board level.

- At one trust, United Lincolnshire Hospitals NHS Trust, we found that educational governance systems were less clear. We were unable to clarify on our visit how educational issues are regularly reviewed at a board level. We set a requirement for this trust to put in place a systematic approach to collection and meaningful metrics regarding education and training.
Case study: The use of non-executive directors on trust boards

Two of the trusts we visited, University Hospitals of Leicester NHS Trust and Kettering General Hospital NHS Foundation Trust, had appointed non-executive directors with the specific remit to champion education and training on trust boards and we met them on our visits.

We found this to be a really positive example of how trusts can make sure training is advocated for, especially when boards are addressing other pressures such as finance and service delivery.

At Leicester, the role of the non-executive director is to ask the ‘tough’ questions about the education and training of doctors, to make sure patient safety remains central to all trust decisions. The non-executive director told us that they also try to make sure the education on offer at Leicester is value for money. They say they work closely with the patient partner lead at the trust to make sure all concerns are relayed to clinical managers and the patient voice is heard at all levels of the trust, including in education.

At Kettering, the non-executive director bridges a divide. They make sure factors that affect medical education and training are regularly brought to the attention of the board. Meanwhile, they give those in senior education roles some insight into the day-to-day service delivery issues faced by the board.

Educational governance

We found that educational issues were well sighted at board level at most LEPs we visited.

Sherwood Forest demonstrated accountability for education and training at board level. We were told that board meetings are held once a month and that issues pertaining to education and training are discussed at board level. Additionally, we heard an example of an educational issue that was discussed at board level and subsequently resolved.

Kettering had clear, transparent educational governance systems and structures in place as well as a strong educational team. The workforce strategy group, a sub-committee of the board, works closely with the medical director and director of medical education to consider and plan ongoing workforce initiatives as there is a keen awareness of the impact of service pressures on medical education.

University Hospitals of Leicester takes a systematic approach, using the analysis of dashboards to define key indicators for the state of education and training throughout the trust. Educational leads in particular use the dashboard to assess quantitative measures such as the frequency of education activity and learners’ attendance. The executive workforce board is chaired by the chief executive at the trust and this is where action plans for each directorate are reviewed. The DME presents a paper to the board quarterly.
At this meeting the DME gets plenty of opportunity to discuss education and training with the board. Following the meeting, the director of education then works with the team to fulfil any actions encouraged by the board.

How the board is sighted on educational issues at Nottingham University Hospitals was less clear, but the education management team has undertaken some positive initiatives which can improve the accountability for educational governance within the trust. This includes strengthening the reporting lines from the Learning and Education Committee to board and introducing a comprehensive education report to be available to the trust board regularly.

Before our visit to United Lincolnshire, the trust told us that issues pertaining to education and training are raised by the DME at the trust’s clinical executive committee, which is the clinical executive decision making group for the organisation. We were told that issues are then escalated to the medical director, who reports to the trust’s board. But it was unclear from the trust’s documentation what mechanisms were in place to make sure the board was informed of education issues. We set a requirement for the trust to review the current educational governance structures and reporting systems and put in place a systematic approach to collection and meaningful metrics regarding education and training.

**Equality and diversity**

During our visits, we found the collation of equality and diversity data on doctors in training or trainers was generally good. Most LEPs we visited are collecting this data.

At University Hospitals of Leicester NHS Trust, senior managers we met said they collate data on equality and diversity. They use this information to make sure they meet the needs of all their learners, including making reasonable adjustments where needed. At Nottingham University Hospitals NHS Trust, they have analysed the make-up of their workforce and are aware that while they have a parity of white and BME ethnicities in the medical workforce, this is not reflected at medical management level. Sherwood Forest NHS Foundation Trust has an equality and diversity lead who reports formally on equality and diversity matters to the organisational development and workforce committee which feeds into the trust board.

We made recommendations for United Lincolnshire Hospitals NHS Trust and Kettering General Hospital NHS Foundation Trust to improve how they analyse their equality and diversity data to make sure their processes are fair, but both trusts were collecting the data systematically.

Although, overall, the collation of this data is good, we feel there is still room for improvement. We have recommended that HEE EM explore how better analysis of this data can measure the impact of its processes on different groups of trainees.

Both medical schools were collecting data and analysing it, for example to make sure assessments are fair. Leicester Medical School has considered whether factors such as
age, disability or ethnicity affect the likelihood of course termination. Whereas male students and those with a declared disability are more likely to have their course terminated, this difference is not large. Nottingham Medical School has recently appointed an equality and diversity lead and has developed an equality and diversity strategy and is now analysing in more detail their equality and diversity data.

**Interactions between staff and medical students**

During our visit to University Hospitals of Leicester NHS Trust we learnt about how students are occasionally subjected to inappropriate comments such as suggestions of particular careers due to their gender. We also found in our meetings with students at the school that some of them had experienced inappropriate, undermining behaviours, including some career advice with a gender bias eg female students being advised to pursue a career in general practice rather than surgery if they wished to have children.

At the medical school, senior managers told us that they do not think there is a culture of this behaviour endemic at LEPs but they do recognise that there are pockets of this behaviour which need to be addressed.

Whereas the behaviour may not be endemic, it is clear that these comments have a big effect on medical students’ morale and self-esteem. This is true of any professional in any environment but we are especially concerned about students being exposed to these behaviours right at the start of their medical careers, at a time when positive and inspiring role models are so important.

We have given the trust and Leicester Medical School requirements to make sure such comments and incidents are monitored and addressed.
Case study: delivering training in a private provider

For the first time in a regional review, we visited a private provider, Circle Nottingham Treatment Centre. The centre is the largest day-case centre in Europe and provides a wide range of outpatient, inpatient, diagnostic and therapeutic services. It is next to Queen’s Medical Centre in Nottingham.

We were interested to see how education and training can be delivered and properly governed in a private provider, without the history and structure supporting training as seen in most LEPs.

Circle Nottingham Treatment Centre is not allocated its own trainees. But it offers training opportunities to trainees who are at Queen’s Medical Centre. In this way, the centre functions like an outpatients department of Queen’s. We found that trainees and medical students (from Nottingham Medical School) spoke highly of the training and support they received at the centre, especially as trainers have a lot of time to teach.

Because of the way training is delivered at the centre, we found that close collaboration with Queen’s Medical Centre was vital, for instance sharing information between a trainer at Circle and a trainee’s educational or clinical supervisor at Queen’s. Senior managers we met would like to develop more formal links between the two organisations and are keen to provide more training.
We heard evidence that LEPs and medical schools provide a supportive environment for doctors in training and medical students. And we heard that robust structures are in place for those with pastoral and academic issues.

- We found that many students at both medical schools felt under a lot of pressure from the demands of qualifying and working as a doctor. However, both medical schools have good pastoral support measures in place. Nottingham Medical School has established a family support scheme where new students are placed with more established students to offer guidance and support. Leicester Medical School pastoral support team has developed an online programme to encourage mindfulness in students.

- Doctors in training told us they are generally well supported in LEPs, by their colleagues and educational and clinical supervisors.

- We were impressed with the work carried out by the professional support unit at HEE EM. The unit gives a lot of work-based coaching to doctors to enable them to address issues themselves, and focuses on educational issues.

- We heard there are problems with accessing study leave throughout the region. The approval process differs between different LEPs and can have a number of steps to go through. This can make it hard to gain approval in time to take leave.
Case study: Widening participation at Nottingham Medical School

Students we met at Nottingham Medical School spoke highly of the support they’d received through the widening participation programme.

The school set up the programme to encourage applications from pupils from disadvantaged backgrounds in the local area, and they offer mock interviews and mentoring, as well as a summer school to support pupils in the application process.

The school also offers a foundation year and students we met spoke highly of the support they have been receiving during the transition from the foundation year to the medical course. The students have only one tutor during the year zero who guides them and ensures consistent teaching. The students praised the foundation year tutor and said the concepts and teaching throughout the foundation year has been immensely useful for the medicine course.

The school has been making sure students from the widening participation programme are supported when they start the standard entry to medicine course. The school has also been collecting data about these students performance once they started the medicine course. The information is analysed and used to identify areas of support and teaching that may need to be added to foundation year. The tracking of this group of students and monitoring of their performance is a good initiative.

We also heard that Leicester Medical School has plans to introduce a widening participation programme, with the intention of increasing applications from local pupils. The school hopes this will lead to more students staying on in the area to work and train after graduating.

The Professional Support Unit

We heard how the professional support unit (PSU) at HEE EM is supporting doctors who are having difficulties with their training. The unit now only accepts referrals from educational supervisors. The PSU made this change to prevent self-referrals around problems they cannot help with. Each referral is risk assessed and if other avenues of support are more appropriate the doctor is referred on, for example if there is a specific health issue.

The unit provides work-based coaching, with an education focus rather than helping with areas such as health issues. As an example, the unit has helped doctors having difficulties passing exams and, following coaching, two thirds of this group go on to pass their exams.

The unit has recently piloted an initiative to help general practice trainees who fail clinical skills assessments, called ‘perfect day’. This involves videoing consultations and giving
detailed feedback, and is based on self-regulation theory. This initiative was in its second year when we visited. Of those who used the service in the first year, 75% percent went on to pass their assessments. The unit is looking at expanding this service to doctors training in all specialties.

Moving to a more proactive service

Partly in response to cuts in funding, the PSU unit is looking to provide a more proactive service. We heard of positive sounding initiatives such as analysing referral trends to see if targeted support can be offered. For example, there were a high number of referrals for exam issues in radiology. The unit worked with the head of school to offer study support training at the beginning of the training programme. The unit is looking to expand this to all specialties to identify those who may need help at recruitment to offer support.
We came across a supportive environment for educators at all of the LEPs and medical schools we visited.

- Educational and clinical supervisors felt well supported at all LEPs. They are given appraisals and training specific to their roles.

- Many educational supervisors in the region had completed training provided by HEE EM and were complimentary about it. The training comprises of face-to-face courses and MedWise, which is an online course run by University of Nottingham School of Medicine in cooperation with HEE EM.

- We found variation in tariff for educational SPAs (supporting professional activities) at LEPs. We also found that it was not always possible for educators to use their allocated time for education purposes.

**Time allocated in job plans for education**

In our visits to LEPs in the region we heard of the variation in time in educators’ job plans. In United Lincolnshire Hospitals NHS Trust educational and clinical supervisors receive 0.125 SPA (supporting professional activities) time per each doctor in training whereas in Nottingham University Hospitals NHS Trust educators receive a standard 0.5 SPAs for their clinical and educational supervision duties regardless of the number of doctors in training they supervise. At Kettering General Hospital NHS Foundation Trust educational supervisors receive 0.25 SPAs per doctor in training up to a maximum of 0.5 SPAs. However, we were told that some consultants were supervising more than two doctors in training.
A bigger issue educators raised was the ability to protect this time in job plans. In Nottingham University Hospitals NHS Trust, the allocated time was not sufficient and educators often had to do e-portfolio work in their own time. During our visit to HEE EM, we heard from heads of school and training programme directors that, across the region, using time allocated was difficult. Heads of school (postgraduate) told us the variability in SPAs and difficulty using allocated time meant there was a risk that consultants would not want to take on such roles in future.

We set HEE EM a recommendation to work with LEPs in the region to look at this variation and how this time can be better protected.

Case study: Support for educators in East Midlands

On our visits around the region, we heard from educators who were appreciative of the support offered by HEE EM.

HEE EM has developed, together with the University of Nottingham, an online training programme, called MEDWISE, for supervisors. We heard that at Nottingham University Hospitals NHS Trust, all educational supervisors have completed this course. Other LEPs may use different training programmes, but they are all quality assured by HEE EM and all recognised trainers have completed accredited training. HEE EM runs an educators’ day, but it will be moved to an online package. HEE EM has also put in place awards for educators and has received many nominations. Educators we spoke to in LEPs appreciated this recognition.

We also heard how HEE EM has supported directors of medical education at LEPs. The postgraduate dean’s approach to driving improvements in LEPs is to invest in educational leadership in these providers. DMEs we spoke to were appreciative of the support and advice they received from HEE EM. We were particularly pleased to hear of the DME’s network, where DMEs in the region get together quarterly, along with HEE EM, to discuss issues and share good practice.

We found that HEE EM’s close relationships with DMEs enabled them to have good, early oversight of potential problems in education and training.
We found that both medical schools had appropriate curricula and that these were being delivered effectively. Both schools were in the process of implementing refreshed curricula and, while this process was being effectively managed, we noted the importance of effective communications with students during these periods of change.

Medical student placements at the LEPs are delivering good coverage of the undergraduate curriculum overall, but there was a wide variation in experience and student satisfaction between placements.

In postgraduate training, we found there was often a tension between service delivery and training. In some specialties, it was difficult for trainees to attend teaching and take study leave due to workload and rotas.

**Workload affecting delivery of training**

Sherwood Forrest NHS Foundation Trust is particularly affected by rota gaps and workload. Some trainees we met told us this means it is often difficult to fit learning opportunities around the rota and attending teaching often results in them using their own time to stay on top of their workload once returning to the ward.

There were similar issues at Kettering General Hospital NHS Foundation Trust where many consultant vacancies are covered by short and long term locum consultants, some of whom are unfamiliar with specific training requirements.

At University Hospitals of Leicester NHS Trust, foundation doctors told us that, at its worst, they were only able to attend 40% of local teaching sessions and often had to come in on their days off to try to meet their training requirements. They reported that doctors in
training were always cross-covering wards due to the design of the rotas and the gaps in rota. But they also told us they had reported this to consultants and had seen recent improvements in rota design since.

At United Lincolnshire Hospitals NHS Trust, rotas are designed to give trainees protected learning opportunities that allow them to meet the requirements of their training programme. The doctors in training we met confirmed their rotas are generally supporting their learning. But we did also hear of heavy workloads and some instances of rota gaps and timetable clashes impacting on training.

At Nottingham University Hospitals NHS Trust, the doctors in training we met during our visit commented on the impact that rota gaps are having on their workload. F1 doctors told us that, although their rotas are compliant on paper with the European Working Time Regulations (EWTR), they are working beyond contracted hours and working time regulations and have no scheduled breaks in their rota. Foundation year two (F2) doctors and those in core medical training said their rotas do not make up for a balanced workload and do not allow them time to attend training as specified in the curriculum. They said they had to attend clinics or teaching sessions when they are off work and take exam days as personal holiday rather than study leave.

Circle Nottingham NHS Treatment Centre does not have the same service pressures as the NHS trusts but training is still affected. Doctors in training get their outpatient day case surgery experience at the centre and most of their inpatient experience at Nottingham University Hospitals NHS Trust. The learners we met said they feel consultants and supervisors at Circle have more time to dedicate to teaching and training. They said that at the centre they can undertake a wide breadth of procedures and gain invaluable relevant experience. Rotas are designed by Nottingham University Hospitals and attendance at Circle is dependent on service commitments at Nottingham. This arrangement requires close collaboration between the two organisations.

We set HEE EM a requirement to continue to monitor and work with LEPs to address the impact of rota gaps and workload on clinical supervision and the delivery of education and training.

**Steps taken to protect training**

We did hear of good initiatives to make sure doctors in training meet their curriculum requirements.

University Hospitals of Leicester NHS Trust runs a clinical experience week which enables doctors in training to attend clinics all week. This was looked on favourably by both trainers and doctors in training because it enabled doctors in training to meet the requirements of their curriculum. Core doctors in medical training told us they were particularly pleased that this week was bleep free.
Most doctors in higher training we met at Lincoln County Hospital were appreciative of the flexible approach to their education and training which makes sure they are meeting their required learning outcomes, despite service commitments.
What next for the East Midlands?

Following our visits to HEE EM, Nottingham Medical School and Leicester Medical School, we’ve set requirements and recommendations for each organisation in our detailed visit reports (http://www.gmc-uk.org/education/26807.asp). They will update us on their progress towards meeting these requirements and recommendations through scheduled reports. HEE EM will also monitor and report updates on the requirements and recommendations from the LEP visits. We will set deadlines for responding to make sure actions taken are timely and appropriate.

We’ll continue to support all our stakeholders in the East Midlands, and will meet regularly with them to give advice and support. This will make sure any challenges in meeting the requirements and recommendations of the regional review can be addressed.

We’ll also take our learning from this review and apply it to our national reviews of Northern Ireland and Scotland, which are taking place in 2017.

We would like to thank everyone involved in this review for their help and cooperation, in providing us with extensive evidence, helping to arrange our visits and making sure students and doctors in training were available to meet us.