Introduction

This report gives a picture of medical education and training across the North West of England in 2013–14. The findings come from our visits to the six local education providers (LEPs), three medical schools and one local education and training board (LETB) in the region.

The maps on pages 4–5 show the location of each of the organisations we visited.

Why did we choose the North West?

We selected this region because:

- we had last visited Manchester medical school, North Western Deanery and Mersey Deanery in 2006, 2009 and 2010 respectively
- some issues of potential concern had been raised through routine reporting, annual surveys and our enhanced monitoring process* 
- Mersey Deanery and North Western Deanery were merged into one LETB, Health Education North West, in April 2013.

What do we know about the region?

We began our review with a good understanding of many of our key issues in the North West. We had visited Liverpool medical school and some associated LEPs in 2011–12, and we have been visiting Lancaster medical school and its main LEP since 2011 as part of a rolling cycle of quality assurance. Lancaster medical school was originally set up as a satellite campus of Liverpool medical school, and our review has been overseeing Lancaster’s bid to become an independent medical school. We also have a network of regional liaison and employer liaison advisers working with colleagues in the North West, giving us a greater understanding of challenges and opportunities within the region.

Manchester medical school is one of the largest in the UK: it has about 350 students in the first year, rising to up to about 450 students in each of the later years. This is because of the addition of students that transfer from St Andrews medical school and International Medical University in Malaysia to complete their studies.

* Enhanced monitoring is the process by which we support medical schools, deaneries and local education and training boards to resolve safety and quality issues in medical education and training. Issues that require enhanced monitoring are those that we believe could adversely affect patient safety, doctors’ progress in training, or the quality of the training environment.
The University of Central Lancashire is the smallest medical school in the UK. It will begin delivery of a private medical programme to about 30 students per year in September 2014. The university is going through a rolling cycle of quality assurance similar to Lancaster medical school and, as delivery of the course has not yet begun, was not part of the regional review.

**What changes have been happening in the North West?**

**Merging the deaneries into one LETB**

From 1 April 2013, deaneries in England were incorporated into multiprofessional LETBs, which manage postgraduate medical education and training for all healthcare professionals within their region. In the North West, the Mersey Deanery and North Western Deanery merged into the LETB Health Education North West. At the time of our visit, the two regions within Health Education North West were still operating independently and planning had started for merging functions across the LETB.

The two geographical regions in Health Education North West operate with lead employer trusts, meaning that doctors in training retain one contract of employment throughout their programmes. Even though the doctors move from one learning environment to another, they do not have to repeat induction or health and criminal record checks each time they move.

**Reviews of quality and service reconfiguration at LEPs**

Blackpool Teaching Hospitals NHS Foundation Trust and Tameside Hospital NHS Foundation Trust are under investigation by the Medical Director of NHS England, Professor Sir Bruce Keogh. This is because both LEPs were outliers for 2011 and 2012 on either the summary hospital-level mortality indicator* or the hospital-standardised mortality ratio.†

University Hospitals of Morecambe Bay NHS Foundation Trust was selected for review under the second phase of the inspection programme because it had an intermediate risk of not meeting the Care Quality Commission’s standards under its new intelligent monitoring system. Services in this Trust are likely to be reconfigured and we expect a consultation on potential changes in 2014.

Services have been reconfigured in Manchester. Central Manchester University Hospitals NHS Foundation Trust was established on 1 January 2009. On 1 April 2012, it took on managing three hospitals that were previously under the management of Trafford Healthcare NHS Trust: Trafford General Hospital, Altrincham General Hospital and Stretford Memorial Hospital.

A new Royal Liverpool Hospital is being built, replacing the current site with a state-of-the-art building. Patients will see benefits like en-suite private rooms, and services will have to change because of an overall reduction in the number of beds available.

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* See www.hscic.gov.uk/SHMI.  
† See http://myhospitalguide.drfosterintelligence.co.uk/#/mortality.
What did we do?

We visited the six LEPs, three medical schools and one LETB in the region between October and November 2013. During the visits, we spoke to students, doctors in training, their teachers and supervisors, and the management teams running the organisations. We also surveyed medical students at all three medical schools before the visits.

We have well developed evidence about postgraduate education and training, and our annual survey of doctors in training has a very high response rate. These visits have helped us to test whether our evidence is accurate and to understand how risks are being managed and standards of medical education and training are being driven up.

In this report, we have summarised the regional themes and listed examples found of good practice and of areas of improvement from each of these visits. You can read the detailed reports of the visits at www.gmc-uk.org/northwest_review.
Health Education North West includes the former:

- North Western Deanery
- Mersey Deanery
- LEPs
- Medical schools
Regional themes

Medical schools and the LETB benefit from strong leadership

We set out the importance of leadership in medicine in our guidance Leadership and management for all doctors and the Medical leadership competency framework. Medical schools and the LETB in the North West show clear commitment to and understanding of the importance of leadership in medicine. As well as creating future generations of leaders, through initiatives like the postgraduate certificate in leadership for doctors in training from Edge Hill University, there is effective leadership in place now.

The postgraduate deans of the former Mersey and North Western deaneries were reported to be supportive and accessible by every LEP we visited and by their colleagues in the medical schools. As well as maintaining excellent relations with their colleagues, both deans take a keen interest in supporting doctors in training when they face difficulties.

Leadership in the medical schools has also been recognised as vitally important. Lancaster and Liverpool medical schools have both been reviewing their curricula, and we heard that the heads of both schools had engaged with stakeholders to ensure their views were incorporated. In particular, the head of Liverpool medical school was recognised for his engagement programme during the first major revision of the curriculum in 20 years. An extensive consultation was undertaken to consider the content of the curriculum, how best to deliver this in the NHS and how to increase emphasis on healthcare in the community.

The head of Lancaster medical school plans to retire in the coming years and succession planning is a high priority. Lancaster University recognises the importance of continuing strong leadership of a developing programme, and maintaining the head’s important ties with the local NHS where she is a non-executive board member.

The leadership team at Manchester medical school has overseen an increase in overall satisfaction in the national student survey from 61% in 2009 to 85% in 2013.

Trainers at some LEPs need more time for education

The consultants and general practitioners (GPs) that supervise and train doctors on the job are important role models for doctors in training. We recognise the need to support these clinicians and professionalise this aspect of their roles. This is through the implementation of the Recognition and Approvals of trainers process for the GMC, supported by the guidance on training developed by the National Association of Clinical Tutors UK and the Academy of Medical Educators, both commissioned by Health Education England.

Health Education North West requires trainers to complete training for their educational role, but, in October 2012, the former Mersey Deanery had reported to us that not all trainers at the Walton Centre had done so. We were pleased to find an improvement in this area with over 90% of trainers having completed the required training; this has been helped by the delivery of an in-house training course.
At North Manchester General Hospital, training for trainers exceeds the requirements set by Health Education North West, and benefits have included increased capacity to provide local support for doctors in training who are experiencing difficulties. Although doctors training in general practice felt well supported by their GP trainers at Aintree University Hospital and Royal Lancaster Infirmary, we found a lack of training for their hospital supervisors.

Ensuring time in consultants’ job plans for training has been challenging with variable practice across the UK, including the North West. At Aintree University Hospital, Manchester Royal Infirmary, North Manchester General Hospital and Royal Lancaster Infirmary, we found that not all staff responsible for educational and clinical supervision had time allocated for education in their job plans. Although we did not find any good practice in this area, consultants at the Walton Centre and Royal Preston Hospital did not report a lack of time in their job plans for training.

We found that requiring doctors nearing the end of their training to undertake a train the trainer course is good practice.

High workload pressures can restrict access to educational opportunities

Even if time is secured in job plans, this is not always used for education and training because of workload pressures. At each of the six LEPs we visited, we found doctors in training and their supervisors working incredibly hard to meet the demands of their jobs in the time scheduled to them. They were frequently working beyond their contracted hours to deliver patient care, often battling with understaffing and covering gaps in rotas.

High workloads can provide good breadth and depth of experience and many clinical cases to learn from. However, such workloads can also make it difficult for doctors in training to access educational opportunities, and there needs to be time for reflection and support for learning.

For example, doctors training in core medicine at Aintree University Hospital and Manchester Royal Infirmary found it very challenging to attend the number of outpatient clinics required by their curriculum. Similarly, doctors training in core surgery at the Walton Centre were spending more time running the wards than in the operating theatre.

Doctors training to be GPs and working at Aintree University Hospital and Royal Lancaster Infirmary were able to identify potential learning opportunities, such as reviewing decisions by GPs to refer patients to the emergency department. However, because of their workload and the pressures on their supervisors, they did not have time to make the most of these learning opportunities.
Regional themes

Case study: general practice

Around half of all students entering medical school will work in general practice: more and more care is being delivered in the community and this is being reflected in the increased focus on community placements in the revised Lancaster and Liverpool medical schools’ curricula.

At all three medical schools we visited, students get experience in general practice. Ensuring a good learning experience in the community is quite different from ensuring it in hospital, with only one or a few students learning in a GP surgery at a time. We have previously required both Lancaster and Liverpool medical schools to strengthen the quality management of general practice placements. This is bedding in well in Liverpool and being developed in Lancaster. There is a good system in Manchester medical school where quality management of all placements is supported centrally by a dedicated team.

The North West has traditionally been an area without enough GPs. To encourage new graduates to consider a career in general practice, the North Western Deanery and now Health Education North West have included at least one community placement in the Foundation Programme, with over 90% of foundation doctors undertaking a placement in general practice. Health Education North West has also been at the forefront of the broad-based training pilot,* the aims of which include encouraging doctors who haven’t yet chosen a career path to consider general practice.

Doctors in GP training had mixed experiences. The one-to-one support and time spent in the GP surgery was praised but, when working in hospitals, doctors thought that they were purely delivering service in many posts rather than being trained to become a GP. Some hospital supervisors were unfamiliar with the general practice curriculum and told us that, over the four-to-six-month placement, they treated these doctors in the same way as doctors training in their specialty. We also found that hospital supervisors had limited access to the GP ePortfolio and that some doctors in training found it difficult to go to regional teaching because of service commitments.

Our national training survey consistently shows that, when working in hospitals, doctors training to be GPs are some of the least content with the quality of their training. This is not specific to the North West and, in 2014–15, we will work with the Royal College of General Practitioners and the Committee of General Practice Education Directors to explore the reasons why.

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* Broad-based training is a two-year structured core training programme, providing six-month placements in core medical training, general practice, paediatrics and psychiatry.
Ensuring students and doctors are working within capacity

Heavy workloads not only stop medical students and doctors in training from accessing educational opportunities; they can also result in them doing more than they are competent to do. Clinical procedures must be undertaken by medical students and doctors who are competent to do so, and it should be clear to supervisors and other allied healthcare professionals that they are competent. This is not always the case and action has been taken locally to ensure medical students and doctors in training are not asked to work beyond their competence.

Medical students must become competent in performing the clinical procedures listed in *Tomorrow’s Doctors* before they are able to graduate. The three medical schools in the North West spend considerable time and effort teaching students these skills in a safe environment before they are allowed to practise under supervision on patients. Manchester medical school has invested heavily in its consultation skills learning centre, where students practise procedures and learn how to talk to patients to get a medical history.

It is important to distinguish medical students from doctors in training so that it is clear what their level of competence is, what clinical procedures they can perform and what level of supervision they need. At Royal Preston Hospital, students from Manchester medical school are clearly identifiable by their grey scrubs with the University of Manchester’s crest on them. Lancaster medical students are issued identification badges with coloured lanyards, indicating not only that they are medical students but also their year of study.

The challenge of distinguishing by level of ability and competence is not unique to medical students. Outdated, inaccurate and unspecific terminology is still widely used when referring to doctors in training. We found many examples of this at the LEPs we visited. We have now required all six LEPs to ensure appropriate terminology is used when referring to doctors in training.

Doctors in the first year of the Foundation Programme (F1) have provisional registration with a licence to practise, which limits their scope of practice. When they complete F1, they can apply for full registration and to begin the second year of the Foundation Programme (F2). Doctors who have completed the Foundation Programme can, if appointed, begin specialty training. However, hospital rotas at all six LEPs remain organised using the terms ‘SHO’ and ‘registrar’. On the so-called SHO rota, there might be a doctor in F2 undertaking a four-month post in a specialty they have never worked in before and a doctor beginning their third year of specialty training. The experience and expectations of these two doctors should be different but, by placing them in a single ‘SHO’ category, it becomes harder for colleagues to understand what they are competent to do and what level of supervision they need.
Run through training

- **Medical school**: 4–6 years
- **Foundation year 1**: 1 year
- **Foundation year 2**: 1 year
- **Specialty or GP training**: 3–8 years
- **GP or Specialist Register**: 9–16 years in total

Core and higher specialty training

- **Medical school**: 4–6 years
- **Foundation year 1**: 1 year
- **Foundation year 2**: 1 year
- **Core specialty training**: 2–3 years
- **Higher specialty training**: 3–8 years
- **Specialist Register**: 11–19 years in total

Descriptions

- **Undergraduate medical education**
- **Foundation training**
- **Core specialty training**
- **Higher specialty training**
- **Full registration**
- **Primary medical qualification**
- **Specialty or GP training**
- **Provisional registration**
- **Certificate of completion of training**
The level of skill and supervision needed can differ within, as well as between, grades of doctors in training. At Royal Preston Hospital, an example of good practice was that new graduates taking up their first post have a clinical skills assessment, which helps to define their training and support needs. The information is shared with clinical and education supervisors to ensure that foundation doctors are given support tailored to their needs.

**Clinical supervision could be improved in some LEPs**

Clinical supervision is key to making sure medical students and doctors in training work within their competence. Before our visit, we surveyed students at Lancaster, Liverpool and Manchester medical schools, and over 70% of respondents agreed or strongly agreed that they received the supervision or instruction required before carrying out clinical procedures.

We noted that:

- doctors in training at Royal Preston Hospital needed clinical supervision when running paediatric clinics
- due to their heavy workloads, doctors in higher specialty training in medicine were not always able to provide clinical supervision for doctors in foundation and core medical training
- on-site cover at Royal Lancaster Infirmary, particularly at night time, was not always provided by someone competent to supervise the doctors in training.

**Processes are in place for raising concerns**

With some exceptions, most students and doctors in training understood the processes for raising concerns if they were asked to work beyond their competence, were not appropriately clinically supervised, or saw practice they did not consider to be in the best interests of patient safety. Where this was not clear, we have required the organisations to give additional guidance and training.

There was an example of good practice at Manchester medical school, where their innovative use of technology to support learning via tablet computers and bespoke software included an alert button. Each student working in clinical areas is given a tablet computer that includes a red alert button, allowing them to instantly raise concerns with the central medical school team. The alerts are constantly monitored and investigated immediately to ensure no students or patients come to harm.

Patient safety data is also collected by the LEPs we visited. At Aintree University Hospital, Royal Lancaster Infirmary and the Walton Centre, we found examples of patient safety data being used in quality control to improve standards of education and training. Initiatives tended to be within departments; developing a more holistic approach by the LEPs would offer the opportunity to build on this good practice.
At North Manchester General Hospital, although quality control issues were sometimes resolved within the department, they were not reported to the medical director or director of medical education to allow them to take a holistic approach and increase general oversight of the quality of training in the LEP as a whole. There are good opportunities for the new team to build and develop a more systematic approach.

At Manchester Royal Infirmary, Royal Lancaster Infirmary and Royal Preston Hospital we found good engagement of the senior team with educational governance and that educational matters were routinely discussed at board meetings or by their subcommittees.

**Most medical students feel prepared for practice**

In 2009, we introduced revised standards and outcomes for undergraduate medicine in *Tomorrow’s Doctors*. For the first time, we asked for all students to be given an opportunity to rehearse the responsibilities they would have as an F1 doctor in one or more of their student assistantships. This included making recommendations for prescribing drugs and managing acutely ill patients under the supervision of a qualified doctor.

All three medical schools we visited have a strong emphasis on apprenticeship style learning in the final year, and both Lancaster and Liverpool medical schools have final exams at the end of the penultimate year of study to allow greater focus on preparing for practice in the final year.

Students nearing graduation at all three schools felt their undergraduate curriculum was preparing them well for work as an F1 doctor, and we met recent Manchester graduates at Manchester Royal Infirmary, who also agreed. The national training survey shows that the proportion of graduates who feel well prepared for practice has increased from 55% to 71% at Liverpool medical school and 65% to 73% at Manchester medical school between 2010 and 2013.

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**Case study: the student assistantship at Manchester medical school**

Students spend four weeks in their final year fully integrated into a clinical team, on the rota with a defined role and responsibilities. Students fill out an end of placement evaluation and, in 2013, 60% of the placements were rated as excellent (85/100) and 15% were given a rating of 100/100 by students.

In our student survey before the visit, 92% of students agreed or strongly agreed that they have received guidance from Manchester medical school about student assistantships, and 96% agreed or strongly agreed that they understood the purpose of their student assistantship.

The student assistantships are robustly quality managed by Manchester medical school with regular short-notice visits and a 48-hour turnaround to investigate student complaints. Every site that has student assistantships has received at least one random visit.
Medical students are well supported as they progress, but some doctors in training need better careers advice

We have previously recognised the excellent student support provided at Lancaster medical school. This is helped by the small cohort size of about 50 students per year. Students report that all staff know them by name. They also know where to access various types of guidance and advice.

Student support at Manchester medical school was also singled out for praise. This has traditionally been a more challenging area for schools with larger cohorts, where students can at times feel anonymous and less connected with their school. About 350 students begin studying at Manchester in the first year, and this rises to about 450 students in each of the later years with students transferring from St Andrews medical school and the International Medical University in Malaysia.

As the course is delivered through problem-based learning, the first-year cohort is immediately broken down into small groups, normally with 12 students in each. These groups become a consistent unit of peer support and form close ties with their facilitators. Each group is allocated up to four student ‘mummies and daddies’ from later years in the course, who they can go to for personal and academic advice. Students also have personal tutors allocated by the university.

From the third year onwards, students are allocated to one of four sectors, which include a main teaching hospital and a number of district general hospitals. This again reduces the cohort size to about 80–100 per sector.

A team in each of the four sectors and an overarching team at the medical school focus on student welfare and professionalism. These teams oversee the transfer of students between phases of the programme, and liaise with students and their placement supervisors to ensure students have the support they need.

The careers advice service at Lancaster medical school, which is also available to students at Liverpool medical school, has been singled out for particular praise. This service is also available to doctors training in the Mersey region and, in previous visits when we met Liverpool graduates, they highlighted the advice they had been given as very useful.

As doctors progressed through training in some specialties, we found that the type of careers advice they needed changed and was not always readily available. Doctors training in core surgery within the Mersey region had poor support with applying for and gaining a place in higher surgical training, and doctors training in neurosurgery at the Walton Centre would have welcomed greater support when deciding which area of special interest to develop.
Good practice and areas of improvement

Regional reviews are risk based – we identify where there might be problems and our visits can help to resolve these issues. The good practice we find during visits, including areas of improvement where problems have been identified and managed locally, are equally important to share.

The table on pages 16–19 summarises the good practice and improvements we found. You can read about these in more detail in the report for each organisation on our website at www.gmc-uk.org/northwest_review.

Lancaster and Liverpool medical schools have maintained and developed many areas of good practice that we found on previous visits.
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<tr>
<th>Organisation</th>
<th>Good practice</th>
<th>Areas of improvement</th>
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<tbody>
<tr>
<td><strong>Lancaster medical school</strong></td>
<td>The school has ensured the involvement of the public and patients in the development of the curriculum.</td>
<td>The school has made significant progress in developing assessments for years 1, 2 and 3.</td>
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<td>The school has improved the timeliness of feedback to students on their special study module so that 95% of marks are returned within four weeks of submission.</td>
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<td><strong>Liverpool medical school</strong></td>
<td>The school has ensured that teachers, LEPs and other key groups have been closely involved in the curriculum development by undertaking an extensive and inclusive listening exercise with its stakeholders.</td>
<td>The progress made in developing a formal quality management process for community-based placements.</td>
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<td>The training of staff in equality and diversity.</td>
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<td>The layout of the objective structured clinical examination (OSCE) stations to reduce background noise.</td>
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<td><strong>Manchester medical school</strong></td>
<td>Strong value in student evaluation with examples of this leading to improvements.</td>
<td>Students’ preparedness for practice.</td>
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<td>Widening participation through its Manchester Access Programme (MAP) including a reduction in the A-level grades required of students in the MAP.</td>
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<td>Excellent communication and early clinical skills training, supported by the consultation skills learning centre.</td>
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<td>Organisation</td>
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<tr>
<td>Manchester medical school</td>
<td>Strong academic and pastoral support for students.</td>
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<td>The innovative use, and excellent application, of e-learning and tablet computers to enhance and support medical education.</td>
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<tr>
<td>Health Education North West</td>
<td>Availability of the postgraduate deans and general responsiveness of Health Education North West to support all those involved in education and training across the Mersey and North Western regions.</td>
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<td></td>
<td>Health Education North West provides the Training the Trainers course for all doctors in higher specialty training. Completion of the training course is a requirement for the completion of specialty training.</td>
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<td></td>
<td>Health Education North West has developed processes to deliver inductions, contracts and Disclosure and Barring Service checks for doctors in training, which minimises the administrative impact of doctors undertaking placements across different organisations during their training.</td>
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<td>Aintree University Hospital</td>
<td>The recognition through doctors in training evaluation that the process for admitting patients to medical wards was not working, and the initiative to address this including the dedicated time of two consultant physicians.</td>
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<td>Organisation</td>
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<tr>
<td>Manchester Royal Infirmary</td>
<td>Its commitment to developing students’ clinical skills.</td>
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<td>North Manchester General Hospital</td>
<td>The particulary good system for collecting evaluation data from, and providing feedback to, doctors training in the paediatric department.</td>
<td>The LEP’s implementation of training for supervisors which exceeds minimum standards required by Health Education North West.</td>
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<td>Royal Lancaster Infirmary</td>
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<td>Royal Lancaster Infirmary’s response to quality management data and patient safety issues at other LEPs within University Hospitals of Morecambe Bay NHS Foundation Trust, resulting in changes to staffing and ward configuration to improve patient safety.</td>
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<tr>
<td>Royal Preston Hospital</td>
<td>The use of simulation and clinical skills assessment for the assessment of foundation doctors, and doctors in the first and second years of specialty training, before taking up their posts within the organisation.</td>
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<td></td>
<td>Undergraduate students from Manchester medical school are clearly identifiable because they wear grey scrubs. This ensures healthcare professionals on the wards are aware of their level of competence and the clinical supervision they require.</td>
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<td>Organisation</td>
<td>Good practice</td>
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<tr>
<td>The Walton Centre</td>
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<td>The Walton Centre understands the importance of providing trainers with the skills needed to train and there is a process in place to ensure this happens. Trainers are supported in undertaking their training role through the provision of an in-house course to enable the attainment of level one training status.</td>
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What next for the North West?

We will continue to visit Lancaster medical school each year as part of a year-on-year quality assurance programme and will monitor the school’s progress towards meeting our requirements and recommendations through these visits.

Liverpool and Manchester medical schools and Health Education North West will update us on their progress towards meeting our requirements and recommendations through their scheduled reports to us. This will include updates on the requirements of and recommendations made to the LEPs where students and doctors are trained.

We will start quality assurance visits to the University of Central Lancashire medical school from May 2014. This will involve visits to the school’s LEPs, including East Lancashire Hospitals NHS Trust where students are expected to complete clinical placements.

We will continue to support all our stakeholders in the North West and will meet regularly with them to give advice and support. This will make sure that any challenges in meeting the requirements and recommendations of the regional review can be addressed. We will also take our learning from this review and apply it to the regional reviews of Thames Valley and of Yorkshire and the Humber, which are scheduled for 2014–15.