

PMETB VISIT TO DEANERY REPORT

Please note: this report is about the postgraduate medical education and training of doctors and not about the level of service provided.

1. Postgraduate Deanery: East of England	
2. Dates of visit: 15 – 17 September 2009	
3. Visiting team	
	Name
Lead visitor	Neil Jackson
Visitor (Shadow Lead)	Graham Cox
Visitor	Martin Beaman
Visitor	Mohammed Siddig
Visitor	Sasha Abraham
Visitor	Alan Kershaw
Visitor	Madeleine Wang
PMETB observer	Sarah Marsh
4. Training providers/trusts/hospitals/GP practices/NHS health boards visited	
<ul style="list-style-type: none"> • Cambridge University Hospitals NHS Foundation Trust, Addenbrooke's Hospital • Norfolk and Norwich University Hospital NHS Trust • East and North Hertfordshire NHS Trust, Lister Hospital 	
5. Contact to whom the visit report is to be sent for factual accuracy check	
Deanery contact name(s)	Email address
Prof Simon Gregory	Simon.gregory@eoe.nhs.uk
6. Existing reports referred to during the visit	
<ul style="list-style-type: none"> • Deanery Quality Management Framework Guide • Deanery strategic/business plan • Annual Deanery Report • Head of School Reports • Deanery monitoring visits • Action plans and follow-up to deanery monitoring visits • LEP annual assessments • Document describing relationship Between East of England and London Deaneries • Other deanery documentation relating to quality management • PMETB Visit report 2006 and associated follow-up • PMETB Evidence including Survey data 	

7. Findings against PMETB's generic training standards for training

The visit team should identify notable practice as strengths of the provision, potential conditions as weaknesses and any actions that you consider essential or desirable under each of these domains. Each finding must be explicitly linked to evidence (either direct experience or from the evidence base presented).

Domain 1: Patient Safety

The duties, working hours and supervision of trainees must be consistent with the delivery of high quality safe patient care.

There must be clear procedures to address immediately any concerns about patient safety arising from the training of doctors.

D1.1 The East of England Strategic Health Authority (SHA) Workforce Directorate reported to the visit team that, on paper, rotas were European Working Time Directive (EWTD) compliant in almost 98 per cent of cases and non-compliant rotas are those within derogations.

D1.2 Through a review of various monitoring reports, the Deanery identified that the impact of EWTD compliance was a cause for concern requiring action. However, these reports also highlight lack of clarity as to where responsibility lies for addressing any concerns - with the LEP or with the Deanery. In all meetings with trainees, the visit team heard of their concerns about the effect of EWTD on patient safety, and of compromised learning opportunities which were echoed in documentary evidence provided for the visit team by the Deanery.

D1.3 Trainees reported the following concerns: compliance with the EWTD which resulted in complex rota arrangements, loss of clinical sessions and an imbalance between service delivery and training which negatively affects the latter. Gaps in rotas were commonplace and have resulted in excessive ward work for junior doctors and poor continuity of care for patients. One example given at Norfolk and Norwich University Hospital was that, on the vascular wards, two junior doctors were expected to look after between 50 and 60 patients, which invariably resulted in poor continuity of care and handover. In another, junior doctors stated that they would frequently be left to cope on gynaecology wards with many patients waiting unacceptably long periods to be seen by their senior colleagues who were in theatre.

D1.4 Volume of work combined with rota gaps result in junior doctors experiencing a decrease in learning opportunities with a corresponding increase in service delivery. Trainees of all grades and trainers commented that it has become increasingly difficult for doctors in training to be released for educational events.

D1.5 PMETB requires that the Deanery and its local education providers (LEPs) have clear procedures to address concerns about patient safety arising from training. While it was clear from evidence provided to the visit team that patient safety is a high priority for the Deanery and its LEPs, the visit team was unable to evaluate the effectiveness of the Deanery's arrangements for monitoring its training providers. The visit team was told that the SHA did not solicit or receive reports on data on serious untoward incidents involving trainees.

D1.6 Norfolk and Norwich University Hospital NHS Trust was able to illustrate the high value it put on patient safety and how it used critical incident reporting as a learning experiences for its trainees. A trainee from this LEP has also been appointed to the Patient Safety Committee and the Trust's newly introduced patient safety walk-arounds. However, at the same LEP, bullying had been reported and the team heard from trainees how the culture amongst healthcare professionals makes critical incident reporting (and thus learning from such events) very difficult. Elsewhere at Cambridge University Hospitals NHS Foundation Trust, Addenbrooke's Hospital, trainees reported a positive and supportive culture concerning critical incident reporting.

D1.7 The visit team noted that, without exception, all trainees commented favourably that the consent process was well explained to them and consent was taken only for procedures which they themselves could perform, trainees were appropriately supervised according to their competence and experience, and clinical supervisors were approachable, helpful and supportive. None of the trainees reported that they found themselves performing procedures that they were not competent to undertake, and trainees were aware of who their educational and clinical supervisors were and how to contact them. Supervisors were also accessible, approachable and supportive.

Domain 2: Quality management, review and evaluation

Postgraduate training must be quality managed locally by deaneries, working with others as appropriate, but within an overall delivery system for postgraduate medical education for which deans are responsible.

D2.1 The Deanery's Quality Management Framework (QMF) is comprehensive and well structured but further work is required to ensure this is embedded through the Deanery and its educational network.

D2.2 It was reported that virtually 98 per cent compliance had been achieved for the implementation of the EWTD, with a total of 120 trainees falling within the nationally agreed derogation arrangements. However, the visit team noted the absence of a formal joint SHA/Deanery monitoring process to assess the impact of the EWTD on the quality of postgraduate medical education and training (PGMET).

D2.3 There is some systematic collection of trainee views and feedback for the purpose of improving the quality improvement of PGMET by using Bristol online surveys (BOS) at the end of posts.

D2.4 The specialty schools are not sufficiently developed as yet to contribute effectively to quality improvement. There is not yet consistency of approach to their structure and visiting process.

D2.5 Awareness of and participation in the National Trainee Survey was patchy amongst trainees, thus mitigating against their important contribution to continuous quality improvement in PGMET.

D2.6 There is currently in place a Service Level Agreement (SLA) between the East of England and the London Deaneries, which underpins the rotation of specialist training programmes across both Deaneries. The operation of the agreement 'takes place in a spirit of mutual cooperation and consultation, on a continuous and informal basis'. The visit team concluded that the SLA was in need of review and formalisation to enable the enhancement of the quality of training in the East of England Deanery for those trainees in cross-deanery specialist training programmes.

Domain 3: Equality, diversity and opportunity

Postgraduate training must be fair and based on principles of equality

D3.1 The Deanery has a transparent policy and process for equality, diversity and opportunity. The policy appeared to be a standard document, although there was no evidence of monitoring the process for compliance. The racial equality scheme action plan clearly identifies monitoring the ethnic background of the workforce. The visit team found that the selection and recruitment process is comprehensive and the Deanery was able to give a breakdown of recruitment in 2009 by gender, age and ethnicity.

D3.2 Training in equality and diversity (E&D) has been provided to most senior staff, trainers, LEP and members of interview panels. The visit team found evidence that the Deanery provides an on-line E&D training package for senior staff and LEPs. There appears to be a policy on updating E&D training for educational supervisors. Trainees are unaware that the Deanery has a policy on E&D, and it is not included in induction programmes and packs for trainees. The newly developed faculty for clinical and educational supervisors' courses does not include an E&D update.

D3.3 The visit team found that the Deanery has a process in place for trainees wishing to work less than full time. The Deanery aimed for slot shares in large centres, and all those who met the criteria were given the opportunity of working less than full time. Funding is not an issue. The less than full time policies and processes, contact details, flowchart and detailed advice are available on the Deanery's website.

D3.4 The SHA has a comprehensive disability scheme. However, there is no clearly identified policy or process for considering adjustments necessary for trainees with special needs or disabilities.

D3.5 The visit team found that there is a varying range of training courses in E& D and Communication with the Home Office for HR staff.

D3.6 There is no evidence that the Deanery collects E&D data to produce reports from the Record of In-Training Assessment (RITA)/Annual Review of Competence Progression (ARCP) process to confirm or refute any problems. The lack of any systematic collection of information on consultant or other undermining (other than the PMETB trainee survey) by the Deanery could result in under-reporting of adverse behaviour.

Domain 4: Recruitment, selection and appointment

Processes for recruitment, selection and appointment must be open, fair, and effective.

D4.1 All those involved in recruitment and selection are trained in selection principles and processes. They have all had E&D training.

D4.2 All appointment panels have lay membership. The appointment process for lay members and definition of 'lay' is unclear, and no policy was identified within the Deanery in this regard. However, the role of the lay member is documented.

D4.3 There is no consistent trainee feedback on recruitment and selection across the postgraduate schools.

D4.4 The appeals procedure for recruitment and selection is freely available on the deanery website. All applicants are required to provide appropriate eligibility for entry into a training programme which includes GMC/GDC registration.

D4.5 Evidence of internal audit review on medical recruitment to identify and promote best practice is welcomed and is an example of good internal quality management (QM) process.

D4.6 The visit team was pleased to see that representatives of the Deanery's recruitment staff and Trust medical staff/HR meet on a quarterly basis to discuss core business and to promote their continuing professional development.

Domain 5: Delivery of approved curriculum including assessment

The requirements set out in the approved curriculum must be delivered and assessed.

The approved assessment system must be fit for purpose.

D5.1 The visit team found that for the audit trail specialties, the curriculum was being delivered at the LEPs. Trainees reported difficulty accessing formal teaching, out-patient clinics and operating sessions, due to the pressure of clinical work on the wards. The visit team was told by the trainees that the rota changes following EWTD had resulted in a reduction in clinical experience. In addition, pressure on trainees to 'back fill' rota gaps resulted in a reduction in theatre exposure. There was no monitoring system in the Deanery to assess the impact of introducing EWTD on education and delivery of the curriculum.

D5.2 The visiting process by the Head of the School of Medicine had identified difficulties in delivering out-patient experience for core medical training (CMT) trainees at Addenbrooke's. The action plan from the visit had resulted in improved access for trainees. The visit team noted that this was an area where the QM system had been effective.

D5.3 Access to operating lists in the Lister Hospital is currently appropriate for curriculum delivery. The visit team was informed of the move of elective in-patient and day-case operating from the current theatres in the Lister Hospital, and all surgery from the QEII Hospital at Welwyn, to a new Independent Sector Treatment Centre (ISTC) on the Lister site. Only 35 per cent of the operating lists will be available for training in the new 'Surgicentre' ISTC. Concern was expressed at executive level that the new contract and operational policy of the 'Surgicentre' could seriously compromise surgical training by significantly reducing hands on surgical experience for the trainees.

D5.4 Trainees reported that access to formal mandatory teaching and training courses and to academic meetings was difficult, due to restrictions in the study leave budget and difficulty in securing study leave time. This is discussed further under Domain 8.

D5.5 Two trainees in core surgical training had to repeat their rotation in plastics and trauma and orthopaedics, as no posts in general surgery were available for their rotation. This led to a delay in the trainees acquiring the necessary competences.

D5.6 ARCP and RITA assessments for the hospital-based specialty trainees were all organised on a face-to-face basis, which was welcomed by trainees and trainers. Surgical trainees experienced difficulty in finding adequate time to complete the Intercollegiate Surgical Curriculum Project workplace-based assessments (WPBAs). Trainees in medical specialties were not completing WPBAs in 'real time' as a formative process.

Domain 6: Support and development of trainees, trainers and local faculty

Trainees must be supported to acquire the necessary skills and experience through induction, effective educational supervision, an appropriate workload, personal support and time to learn.

D6.1 The visit team found that not every trainee starting a training post/programme had access to a departmental or trust induction. This was attributed to the trainees having started on night shifts or annual leave, with no arrangements having been made to rearrange the induction. Trainees from the Addenbrooke's and Lister hospitals reported the hospital induction to be appropriate. However, the departmental inductions at these hospitals were reported to be of variable quality, with most trainees not even receiving these. There appeared to be no safety net in the local education programme to ensure that those missing inductions were accounted for. These omissions have the potential to affect both trainees and patient safety (see Domain 1). The visit team noted that this appeared to be related to start date. If trainees started their posts in August, then they generally received the induction programme. However, those starting in September or October tended not to

receive any form of induction.

D6.2 Trainees at Norfolk and Norwich reported that the quality of the hospital induction was poor, information such as computer passwords and how the bleep system worked, not being provided at the induction. However, departmental inductions in obstetrics and gynaecology and in surgery were noted to be of high quality.

D6.3 Trainees were confident that they could share any educational concerns with an appropriate member of faculty if needed; however, none had yet needed to express any matters of concern.

D6.4 All trainees had a designated educational supervisor. In Norfolk and Norwich, the hospitals had set out a job description for educational supervisors. All trainees felt that their educational supervisor was the first point of contact should a problem arise, and most were easily accessible and were meeting their trainees on a regular basis.

D6.5 Trainees were generally pleased with their training and its educational content, and were appreciative of the educational support they received. However, the following issues were raised as areas for improvement as outlined in the report below.

D6.6 At Norfolk and Norwich Hospital, surgical and obstetrics and gynaecology trainers stated that, although their rotas were compliant with the EWTD, they did not think that adequate training could be provided within the confines of the new timescales. The trainees reported a lack of continuity of care resulting from the new working hours, and raised the fact that they were unable to follow up the management of patients across multiple shifts, which was an issue that was affecting their longer-term learning opportunities.

D6.7 At the Lister Hospital, there was no diary exercise monitoring and most trainees reported working for more than 48 hours a week. Across the Deanery, due to gaps in the rota, senior trainees were having to cover additional shifts, and were subsequently losing valuable learning opportunities in theatre, which they considered affected their training.

D6.8 At Norfolk and Norwich Hospital, trainees confirmed that they were able to attend relevant timetabled and organised educational meetings in their hospitals, with protected time allocated for this. However, regional teaching was not well advertised, and many surgical trainees only attended one out of four sessions in the previous year as they were unaware that the sessions were being run.

D6.9 Surgical trainees at Norfolk and Norwich Hospital lacked opportunities to conduct surgical training lists. This was reported to be an issue that was raised two years ago, although it appears that no such list has yet been put in place.

D6.10 Trainees in both primary and secondary care do not have access to training in generic professional skills, such as leadership or management.

D6.11 Trainees and trainers reported undertaking WPBAs, maintaining e-learning portfolios, and regular educational supervisor interviews to monitor progress and set goals. However, there was concern expressed by the trainees about the robustness, quality and rigour of these assessments. Trainees had a cynical attitude to the WPBAs. Although they agreed that face-to-face ARCP was good, they felt that it was only a formative process, ill-suited to summative assessment for trainers and trainees, with most performing easy tasks and choosing assessors who marked generously.

D6.12 It was reported that there was inadequate continuity through rotations in the educational management of trainees in difficulty. Trainees identified as requiring additional support during one rotation did not necessarily receive such a higher degree of support during their subsequent rotations.

D6.13 At the Lister Hospital, plastic surgery trainees reported having to conduct a repetitive, administrative activity of no educational value, during which they had to code all of the discharge summaries for the department.

D6.14 The trainees reported no problems with gaining access to study leave, although they stated that the study leave budget was not sufficient to cover core specialty courses. No deanery monitoring was in place to measure the impact of the limited study leave budget on the quality of education. Trainees did not appear to be aware of the Deanery's policy on study leave or the appeals process. This is addressed further in Domain 8.

D6.15 The visit team received positive feedback from Cambridge University Hospitals NHS Foundation Trust, Addenbrooke's Hospital, trainees and trainers regarding the quality of the academic rotations. It is of note that the academic trainees in renal medicine were particularly complimentary about the programme, with trainees being given the opportunity to attend international conferences and to attain higher postgraduate qualifications. All felt that they were gaining sufficient research and clinical experience.

D6.16 Furthermore, there was academic and clinical representation on all academic ARCPs. The academic trainers have good working relationships with the Deanery, which supports academic programmes.

D6.17 The visit team found no concerns with regard to the availability of ad hoc, on-site (hospital-based) senior support and the provision of advice to specialty trainees.

D6.18 Although standards for hospital trainers are not a mandatory PMETB requirement until 2010, the team looked at the progress made towards meeting this requirement. It was found that the Deanery was being proactive in training educational supervisors through the joint Deanery/University of Bedfordshire Faculty Development Programme in order to ensure their development and to enhance the standard of trainers.

D6.19 It was reported that the quality of general practice (GP) trainers was of a high standard. Trainers currently undertake a course every three years, and a personal development plan every year. GP trainers had recently completed 360-degree feedback assessments. One concern raised by GP trainers was that there had been a sudden expansion in the number of trainees but no corresponding increase in the number of programme directors.

D6.20 A model of good practice was the Public Health Department, in which formal policies had been well documented and were easily accessible. The administrative staff and trainees spoke in praise of this Department for its efforts in this regard. The visit team was also impressed by the coherent structure and function of postgraduate medical education and training in public health at all levels in the education and training system.

Domain 7: Management of education and training

Education and training must be planned and maintained through transparent processes which show who is responsible at each stage.

D7.1 Training programmes are supported by specialty schools within the Deanery, but there

is no clear central deanery strategy on the composition of school boards. For example, emergency medicine has no lay representation and there is no clear central deanery strategy on the way that schools should gather information to ensure quality control. The School of Medicine has visited multiple LEPs, but there is no evidence of a similar process being currently undertaken by the newly formed School of Pathology. While the associate deans receive an appraisal for their educational role, there is no appraisal plan in place to support the role of the heads of school or training programme directors.

D7.2 The recently produced *Trainees in difficulty* policy starts to identify where problems will be addressed, but there is no clear identification of what supportive resources are available within the Deanery to help manage this cohort of trainees, whose conduct, health or progress are giving rise to concern.

D7.3 While different LEPs have different internal structures for managing and quality controlling education, they all have sessional time allocated to an identified trust lead for medical education. They are members of the Trust Executive and represented at board level through the Medical Director who is the accountable Executive Director in the trusts visited by the team. The identification and remuneration of college tutors with sessional time for managing training and education at LEP level is a welcome development implemented by the Deanery.

D7.4 At the meeting held with the education/postgraduate centre managers, the visit team was impressed by their liveliness, innovation, support and leadership for PGMET.

Domain 8: Educational resources and capacity

The educational facilities, infrastructure and leadership must be adequate to deliver the curriculum.

D8.1 Physical facilities, such as libraries, books and journals, meeting rooms, and laboratories, are generally of a high standard and adequate for the purposes of the curriculum. Trainees and trainers commented favourably on these in the locations visited by the team. Libraries and librarians were often singled out for particular praise, with evidence of recent investment.

D8.2 Trainees reported few problems with access to facilities, although both they and trainers reported difficulties, in some places, in downloading multimedia applications contained in the E-Learning for Health programme, where hospital IT systems did not adequately support this. Some trainers pointed out that this programme used some cutting edge applications which were beyond the capacity of older IT systems, and others commented that provision was being made for trainees to have access to a computer which was better equipped to allow them to download the material they need.

D8.3 The visit team was told that the web-based Medical Master Class accessed through the Deanery was of high quality. Access to web-based electronic learning packages in the Lister Addenbrooke's Hospitals, was significantly hampered by poor IT infrastructure in those LEPs.

D8.4 Trainees at the Lister Hospital, reported failed attempts to access legitimate medical websites containing material required for their training, which had been blocked on the hospital's system.

D8.5 Study leave is a significant problem, recognised by Deanery managers and trainers and vocally raised by trainees. The round of expenditure cuts initiated by the SHA in 2006 resulted in a cut of some two thirds in the sum made available annually for each trainee post. This has not been made good and the annual allowance now stands at £320, markedly

below the national norm and readily observed by trainees meeting their peers from the London Deanery, who receive an allowance of £820, as a serious disparity.

D8.6 There is a perception among trainees in general that the study leave policy is not applied consistently across the Deanery, that there is no means of ensuring that all trainees receive the full benefit of the annual allowance available to them, and that the Deanery needs to take the initiative in reviewing and regularising arrangements and support for study leave. The Chief Executive of the SHA recognised the need for significant progress on this and indicated sympathy for improving the resources available.

D8.7 Addenbrooke's Hospital now tops up the allowance to £400, a gesture appreciated by trainees, but this still remains below the national norm. Trainees in CMT at the same trust reported serious obstacles in securing time off to attend courses, so that these had to be undertaken, if at all, during annual leave, which they perceived as unfair. Trainees in other specialties and trusts indicated that this was not a problem for them.

D8.8 Arrangements are in place for supporting trainers in their teaching skills. All trainers in general practice are required to complete the Postgraduate Certificate in Medical Education, and the programme of visits by the School of General Practice focuses on teaching skills, including video observation of trainers in action.

D8.9 There is an established Faculty Development Programme, providing strong support in the delivery of the programme. Administrative and secretarial support for training programme directors has been substantially increased over the past year.

D8.10 Central training of consultants in the principles behind, and conduct of, WPBAs and ARCP were well attended. The Deanery is beginning to monitor consultants' progress with cascading that training to their colleagues locally.

Domain 9: Outcomes

The impact of the standards must be tracked against trainee outcomes and clear linkages should be reflected in developing standards

D9.1 The Deanery, through its QMF Operational Guide, is responsible for developing and maintaining robust reporting and monitoring systems, and its formal mechanism for receiving outcome data from its stakeholders is through the Quality Management Group. The Deanery's Annual Report and Action Plan 2008-2009 identifies trainee access to outcome data on assessments and examinations as a concern requiring remedy. The Deanery's senior management team acknowledged that its systems are in their embryonic stages. With the exception of E&D data collections, which are recorded during the trainees' selection and recruitment process, data recorded for other monitoring outcomes, such as examination passes, attrition rates and trainee progression, is inconsistent.

D9.2 The Deanery did not provide the visit team with any additional outcome data. However, the visit team noted that some school boards report robust data on examination results and attrition rates, while others record little or nothing accessible to trainees.

D9.3 Trainees informed the visit team that they have limited knowledge of deanery-wide outcomes. In some specialties, information on outcomes is available from trainees' respective colleges and, with few exceptions, the trainees interviewed were familiar with progression rates only for their peer groups and specialty.

D9.4 The visit team noted that outcome data for academic trainee recruitment, progress,

publications and examination results was available and showed that the academic trainees are frequently successful in gaining nationally awarded research grants and academic posts.

8. Findings against PMETB's standards for deaneries

Each finding must be explicitly linked to evidence (either direct experience or from the evidence base presented).

Standard 1: The postgraduate deanery must adhere to, and comply with PMETB standards and requirements.

S1.1 There are well intentioned aims within the Deanery to improve the quality of training to ensure that PMETB standards are met. Further developmental work is required by the Deanery with the SHA and its network of LEPs to ensure that standards are complied with at all levels in the postgraduate education and training system.

S1.2 There is clear evidence that the Deanery's QM activities are set and reported within the framework of the published PMETB standards and requirements of training.

S1.3 While the principle of educational governance is understood within the Deanery, further development is required to ensure that it is exercised uniformly across the Deanery as a whole, through its postgraduate specialty schools and through its educational network to LEPs.

S1.4 Further work is required by the Deanery to discharge its responsibilities for the implementation of programmes effectively, to ensure that this is properly embedded from deanery level to LEPs and would secure a clear and meaningful connection between quality management and quality control.

S1.5 The Deanery has provided an annual report to PMETB for the year 2008-09, using the annual postgraduate deanery PMETB template, and this was made available to the visit team in advance of the visit. This is also linked to an action plan for the year 2009-10.

Standard 2: The postgraduate deanery must articulate clearly the rights and responsibilities of the trainees

S2.1 The visit team met with a range of trainees, working throughout the Deanery, and the trainees had the opportunity to raise matters of concern. The visit team concluded that communication between trainees and the Deanery was generally poor. This was evidenced by a lack of awareness among trainees of the Deanery's various policies, such as the Bullying and Harrassment Policy. Improving opportunities for trainees to communicate directly with the Deanery's high-level structure is an area for development, as is improving downstream communication processes to allow the Deanery to disseminate policies and other information to trainees and to allow trainees to have their views represented.

S2.2 Non-surgical trainees did not appear to have a full range of opportunities to raise concerns, either individually or collectively. Sources of impartial help, advice, guidance and support for trainees were not readily available or advertised. The Deanery appeared to have quarterly meetings to allow surgical trainees to express their concerns, which was well represented by trainers and trainees. Non-surgical trainees felt that they lacked similar opportunities.

S2.3 Trainees felt that they would happily speak to their educational supervisor if they had a problem. However, if they could not talk to their educational supervisor, then they were not sure whom to approach.

S2.4 Norwich and Norfolk were in the process of developing a bi-monthly open trainees' forum meeting which would have included the attendance of the Medical Director and Clinical Tutor, although none of the trainees or trainers had yet heard about this. An innovative model of good practice is the Chief Resident post implemented at Addenbrooke's, which invites a senior trainee from each clinical division to sit on the management board. The trainees met by the visit team provided very positive feedback on this innovative post and how it gave them valuable management experience.

S2.5 The visit team was aware of PMETB survey results highlighting issues around consultant undermining behaviour at the Lister Hospital and confirmed that the issues were still current. Those affected were unclear where to go for assistance and impartial advice, and there was a perception amongst the trainees that the Trust had done little to resolve the issue. The "Doctors in Difficulty" policy did not adequately address these concerns.

S2.6 The trainees were clear in their appreciation of the clinical training they received. The visit team heard that the trainees would recommend their jobs to their colleagues. However, the visit team noted problems with the completion of previous PMETB surveys and also a general lack of awareness among trainees of the Deanery's policies and strategy. Some trainees at Norwich and Norfolk had never heard of the survey. Some trainers also raised concerns, stating that they felt this was not a properly validated survey and that it would therefore yield unreliable data that could not be used to draw appropriate conclusions.

S2.7 A 'careers lead' had been appointed at the Deanery four months before the visit, to spearhead a new initiative to provide trainees with independent careers advice. This lead is due to appoint careers leads for each specialty. The heads of the specialty schools have also announced their careers leads. There is a need for further development in this area, for example, to formalise this currently somewhat informal process.

Standard 3: The postgraduate deanery must have structures and processes that enable the PMETB standards to be demonstrated for all training and trainees within the sphere of their responsibility

S3.1 The Deanery has developed a good QMF. It sets out structures and processes to be adopted and PMETB standards to be achieved. The responsibility is then delegated to the LEP network in liaison with Royal Colleges. The newly appointed Dean is committed to active engagement and viable channels of communication with the SHA. The current system of QM is clearly identified and action plans drawn up, but implementation is at an early stage of development and there is a lack of systematic collection and analysis of data and of effective feedback.

S3.2 The Deanery reported to the visit team the organisation and development of specialty schools. Some of these deanery postgraduate school boards include trainee representatives and a lay member. The heads of school have implemented a visiting programme to address issues arising from the trainees' survey with the LEPs, and an action plan has to be drawn up for the year 2009–10. The visit team found no formalised system for monitoring and no systematic approach for collecting data from the meetings. The roles of the heads of school, training programme directors (TPDs) and clinical and educational supervisors were well defined and explicitly stated.

S3.3 The Deanery's recently produced 'Doctors in Difficulty' policy is not inclusive and remains to be tested. However, there seemed to be a lack of connection between the

Deanery and the trusts, trainees and trainers with whom it works. For example, there did not seem to be a clear communication path for the TPD to alert the Director of Medical Education of the next trust when a trainee is in difficulty. Most of the trainees are aware of whom to contact if they are in difficulty.

S3.4 Deanery faculty development for accreditation of education and clinical supervisors is an excellent way forward. This will help to promote the development of a system within the Trust to ensure that all LEPs involved in training have evidence of appropriate competences.

Standard 4: The postgraduate deanery must have a system for use of external advisers

S4.1 External specialty input was found to be variable within the Deanery. Evidence was found of external input into the annual assessments and visits within the schools of surgery and ophthalmology. There was no deanery policy relating to the use of external advisers in all of the specialty schools or in deanery visit teams.

S4.2 There was some evidence of the use of lay members on appointment panels, and school boards. The Deanery's definition of 'lay' was opaque, and there was no consistent deanery process used to recruit independent lay members. In some of the appointment panels, deanery or postgraduate centre employees were used as lay members of panels, despite the fact that they were not independent of the appointment process.

Standard 5: The postgraduate deanery must work effectively with others

S5.1 The visit team welcomed the determination of the newly appointed Postgraduate Dean to build effective working relationships with external agencies and groups. These were founded on a clearly articulated vision for education and training, strong communications both formal and informal, a clear understanding on all sides of roles and responsibilities, and the stated willingness of the SHA Chief Executive to work with him in this.

S5.2 The legacy of the unpredicted round of severe expenditure cuts initiated by the SHA in 2006 has continued to inhibit working relations between the two organisations. Senior staff, including associate postgraduate deans, perceive that resource constraints are driving an approach which is pragmatic and operational rather than aspirational and strategic; education is not yet perceived to be high on the SHA's agenda. Formalising and sustaining future working relationships between the deanery and the SHA will be crucial to overcome the legacy of poor communications, lack of clarity of respective roles and responsibilities and the absence of a shared vision between the two.

S5.3 There are concerns by some LEP senior staff about funds passing from the Department of Health or the Deanery to LEPs not being ring-fenced for the intended educational purposes.

S5.4 The Deanery's description of itself as 'multi-professional' is recognised by the Postgraduate Dean and others as less than meaningful in its present stage of development. However, the visit team was more concerned by the practical difficulties caused by the Deanery currently effectively operating as two units - the School of General Practice and the remaining specialty schools. This mediates against the benefits of a blended deanery through the integration of the primary and secondary care elements of the organisation.

S5.5 The visit team noted and welcomed the imminent relocation which will bring all the

Deanery's staff together on the same site, and to which staff are looking forward. However, the visit team considered that geographical relocation did not, of itself, constitute any guarantee that all parts of the organisation would begin to operate as a harmonious whole, given the lack of evidence of any significant steps, for example, the development of generic skills training, to overcome the difficulties inherent in split sites.

S5.6 In meeting trainees, the visit team found little evidence of significant awareness of what the Deanery stands for, what it does for them and how to approach it. Visits to the Deanery's website appeared to be confined to searches for information about the names of individuals needed for particular purposes. Trainees perceive their educational relationships as, essentially, with their trainers and employers.

S5.7 The Deanery has yet to make trainees generally aware that it is not a remote body of little practical relevance to them, although they reported that they have found the online Medical Master Class, available through its website, to be a valuable resource.

S5.8 Trainers reported that, despite resource constraints, trainees receive an educational experience to underpin safe, competent practice in all specialties. The need for the Deanery to ensure that the programme of school visits to trusts is robust and consistent is commented upon elsewhere in this report.

S5.9 The Deanery's working relationships with the University of Cambridge, the Royal Colleges and the London Deanery, with which some rotations are shared, are reported by the Deanery to be harmonious and effective.

Summary

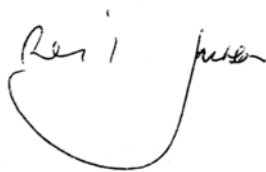
Strengths

- The trust medical staffing/deanery staff quarterly meetings, which include both core business and continuing professional development. (para D4.6)
- The quality of academic programmes and the support provided by the Deanery and trainers. (paras D6.15, D6.16)
- The Deanery's commitment to faculty development and training, particularly as offered by the joint Deanery/University of Bedfordshire Faculty Development Programme. (paras D6.18, D8.8, D8.9, S3.4)
- The coherent structure and function of postgraduate medical education and training in public health at all levels in the education and training system. (para D6.20)
- The postgraduate centre managers are lively, innovative and exhibit leadership for postgraduate medical education and training. (para D7.4)
- The innovative Chief Resident post at Addenbrooke's Hospital (Cambridge University Hospitals NHS Foundation Trust) offers a developmental managerial role for trainees with engagement at a high level in the Trust. (para S2.4)
- The recently established closer working relationship between the SHA Chief Executive Officer and Postgraduate Dean. (para S5.1)
- All trainees met in all of the LEPs reported positive practice regarding consent (para D1.7)
- The Deanery shows a high level of support for flexible working, reflected in its policies and practices (D3.3)
- The Deanery's internal audit review on medical recruitment to identify and promote best (para D4.5)

Areas for Improvement

- There is an absence of a formal monitoring process to assess the impact of the EWTD on postgraduate medical education and training, including patient safety, trainee safety, service/education, curriculum delivery, and the quality of education and training. (paras D1.2, D1.3, D1.5, D2.2, D6.6)
- There is inconsistency in critical incident reporting involving trainees across the LEPs and to the SHA, which could lead to patient safety issues and compromise learning opportunities. (paras D1.5, D1.6)
- There is a lack of deanery profile, and lines of communication with trainees are poor. (paras D2.3, S2.1, S5.6, S5.7)
- There is a lack of consistency in the structure and operations between the schools and in their integration and functions within the deanery. (paras D2.4, D7.1, S3.2)
- The Deanery's monitoring of the effect of the current study leave budget, which is well below the national average, on the quality of postgraduate medical education and training is inadequate. (paras D5.4, D6.14, D8.5, D8.6, D8.7)
- Not all trainees have appropriate inductions at both trust and departmental levels, and there is no coordinated approach across induction to ensure trainees receive adequate information. (paras D6.1, D6.2)
- The resources available to support the implementation of the Deanery's Trainees in Difficulty policy are not clearly defined and its effectiveness has not been demonstrated. (paras D7.2, S2.5, S3.3)
- A culture of consultant undermining behaviour, including bullying relating to critical incident reporting, has not been consistently and appropriately dealt with at deanery/LEP level and some trainees are reluctant to report cases for fear of adverse career impact (paras D1.6, S2.5)
- There is a lack of systematic collection and analysis of data and of effective feedback to trainees in relation to the Deanery's quality management system. (para S3.1)
- There is no transparent policy for the appointment and use of lay persons to the work of the Deanery. (para S4.2)
- There remains a need to overcome the legacy of poor communications between the Deanery and the SHA, the lack of clarity in their respective roles and responsibilities, and the absence of a shared vision between the two. (para S5.2)
- There is a lack of integration across the primary and secondary care elements within the Deanery which prevents the development of a functional multiprofessional deanery. (para S5.4)
- There are issues with capacity for surgical training within the deanery which have negatively impacted on trainees. (paras D5.3, D5.5, D6.9, D6.13)
- There is a lack of quality management processes to review the effectiveness and implementation of the service level agreement with London Deanery. (para D2.6)
- Some trainees are not able to effectively access appropriate IT content necessary for learning. (para D8.2)

Signature of Leader Visitor



Date 7th October 2009

Decision of VTD Panel

The provision at East of England Deanery has:

Met with conditions the standards and requirements of PMETB

Notable Practice:

1. Specialty academic programmes and the level of support provided by the Deanery and trainers.
2. The coherent structure and function of postgraduate medical education and training in public health at all levels in the education and training system.
3. The innovative Chief Resident post at Addenbrooke's Hospital (Cambridge University Hospitals NHS Foundation Trust) offers a developmental managerial role for trainees with engagement at a high level in the Trust.

Conditions:

If timescale is not specified, evidence that the condition is met must be provided with the next annual deanery report.

1. The Deanery must assess the impact of the EWTD on postgraduate medical education and training, including patient safety, trainee safety, service/education, curriculum delivery, and the quality of education and training.
2. The Deanery and LEPs must together ensure that critical incident reporting involving trainees is happening consistently across the LEPs via appropriate channels, with an update to PMETB in six months.
3. All trainees must have appropriate inductions at both trust and departmental levels, with an update to PMETB in six months.
4. A culture of consultant undermining, including bullying relating to critical incident reporting, must be addressed and appropriately dealt with at deanery/LEP level, with an update to PMETB in six months.
5. The Deanery must monitor the effect of the current study leave budget on the quality of postgraduate medical education and training with an update to PMETB in six months.

6. The Deanery must systematically collect and analyse outcomes data and effectively feedback to trainees.
7. The Deanery must ensure there is sufficient capacity for surgical training to maximise learning opportunities.

Recommendations:

1. The Deanery should work to raise its profile amongst trainees and enhance lines of communication.
2. The Deanery should ensure consistency of structure and function of the specialty schools.
3. The Deanery should clarify the resources and support available to trainees in relation to its Trainees in Difficulty policy and communicate this to trainees and trainers.
4. The Deanery should ensure there is a consistent policy in place regarding the appointment and use of lay persons to the work of the Deanery.
5. The Deanery should continue to work closely with the SHA to ensure good communication and clarity in their respective roles and responsibilities.
6. The Deanery should consider the integration of primary and secondary care elements across the deanery.

Signature of Chair of VTD Panel

Namita Kumar

Date 27 November 2009