

# Regional review of medical education and training in the south west of England: 2016



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## Introduction

This report aims to provide an overview of medical education and training across the south west of England in 2016 aligned with the themes set out in [\*Promoting excellence: standards for medical education and training\*](#). The findings originate from our visits to six local education providers (LEPs), four medical schools and the two Health Education England local offices in the region.

### Why did we choose the south west?

Our [schedule of regional visits](#) outlines our visits of each region and country within the UK over a seven-year period.\* We visited the south west in 2016 as part of this schedule.

### What do we know about the region?

With respect to undergraduate medical education, there are currently four medical schools in the south west of England.

- **Bristol Medical School (BMS)** was established in 1833, and became part of the University of Bristol in 1909. There are significant curricular changes underway at BMS to develop and implement a new curriculum. We last visited BMS in September 2014 as part of our audit of undergraduate assessment practice across UK medical schools.†

\* Wales, West Midlands and London are not listed as they were visited in 2012–13 and 2013–14.

† 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).

- **Peninsula College of Medicine and Dentistry (PCMD)** was established in August 2000. However, it is currently in the process of disaggregation into two separate medical schools: University of Exeter Medical School (UEMS) and Plymouth University Peninsula Schools of Medicine (PU PSMD) and Dentistry. PCMD only had students in years 4–5 at the time of this review.
- **UEMS** is a new medical school and accepted its first students in 2013. It only had students in years 1–3 at the time of this review. We last visited UEMS in April 2015 as part of our process of approving new schools.\*
- **PU PSMD** is a new medical school which also accepted its first students in 2013 and only had students in years 1–3 at the time of this review. We last visited PU PSMD in March 2015 as part of our process of approving new schools.

There were a total of 2,617 medical students in the south west during the 2015–16 academic year.

With respect to postgraduate medical education and training (PGMET), ultimate accountability for PGMET sits with Health Education England, and 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 replaced by four LETBs. The South LETB covers the south west area. The body responsible for managing postgraduate education and training across the south west of England is HEE SW,<sup>†</sup> with local offices based in Severn and Peninsula and accountable to Health Education England. There were a total of 3,581 doctors training in the south west at the time of this review in 2016.

Professor Martin Beaman was appointed Associate Postgraduate Dean in the south west in 2000 and became the first Postgraduate Dean for South West Peninsula in 2005. He assumed responsibility for the Severn programmes in November 2013, as part of his overarching role with Health Education England across the south west (HEE SW). HEE SW is now one organisation.

At the time of our regional review, there was one NHS trust in the south west subject to our enhanced monitoring process.<sup>‡</sup> HEE SW proactively uses the enhanced monitoring process as a valuable resource for quality managing the trust.

\* You can find the process for approving new schools on our website at: [www.gmc-uk.org/education/approvals\\_new%20institutions.asp](http://www.gmc-uk.org/education/approvals_new%20institutions.asp).

<sup>†</sup> <https://hee.nhs.uk/hee-your-area/south-west>.

<sup>‡</sup> 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 that we believe could adversely affect patient safety, doctors' progress in training, or the quality of the training environment.

## Geographical location: the challenges

In the south west, recruitment is a challenge – particularly in some of the more remote areas. The geography of the region means that travel times between trusts can be lengthy and it can be difficult delivering regional teaching in locations that all doctors in training can access easily. To manage these geographical issues, postgraduate training in the south west is often divided over two separate training programmes for each specialty: one in Severn and one in Peninsula. Each of these specialties may therefore have two separate heads of school. HEE SW has been operating across two HEE local offices and is working to align processes across the two to improve consistency.

## What did we do?

To understand the experience of medical students and doctors in training in the south west, we visited six local education providers (LEPs), BMS, UEMS, PU PSMD and HEE SW between April and July 2016.

One visit team was attached to the three medical schools (PCMD was covered by both Exeter and Plymouth teams) and each team visited LEPs related to each school. It was neither viable nor necessary to visit every LEP in the region, so we selected two sites for each team in Bristol, Exeter and Plymouth. Members of each team also visited HEE SW.

We chose the six LEPs based on evidence from our [national training survey](#) and other sources of evidence mentioned below. We also took into account intelligence provided by our network of regional liaison and employer liaison advisers.\* The LEPs chosen were:

### Bristol team

- Gloucestershire Hospitals NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust

### Exeter team

- Royal Devon and Exeter NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust

\* 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. Employer liaison advisers work with employers across the UK to create closer working relationships with the General Medical Council (GMC).

## Plymouth team

- Plymouth Hospitals NHS Trust
- Torbay and South Devon NHS Foundation 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 across the UK once a year through our national training survey. \* We looked at the results for the south west of England and how they compare nationally to help us identify areas to explore during the visits.

Other sources of evidence used to identify which LEPs to visit and which specialties to focus on during the visits included:

- scrutiny of routine reports from the medical schools and HEE SW
- previous quality assurance visits we had carried out within the region and any other ongoing quality assurance activity – we aim to be proportionate
- numbers of foundation, core and higher specialty doctors training at each site in the selected specialties – we need at least three doctors in each cohort
- number of medical students located at each site – we need to visit sites that have adequate numbers of students
- the need to factor in the geographical range of LEPs in the region.

This report summarises the regional themes and areas that are working well, as well as those where improvements are needed. You can read the detailed reports of the individual site visits on our website at: [www.gmc-uk.org/education/26814.asp](http://www.gmc-uk.org/education/26814.asp).

\* You can find out more about our national training survey on our website at: [www.gmc-uk.org/education/surveys.asp](http://www.gmc-uk.org/education/surveys.asp).

We have well-developed evidence about postgraduate training. Our annual survey of doctors in training has a very high response rate and gives us a great deal of information on the quality of training across the UK. We also receive routine updates from the HEE local offices on their progress in addressing concerns they have identified through their local quality management processes.

We receive routine reports from medical schools. During 2015, before our visits, we carried out a survey of medical students from BMS, UEMS, PU PSMD and PCMD, to learn more about their experiences at medical school and while on their clinical placements at LEPs. 40.2% of medical students at BMS, 26.8% of medical students at UEMS, 48.6% of medical students at PU PSMD and 32.6% of medical students at PCMD 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. Historically, this has been done by selecting multiple specialties, usually from a range of schools. But for our review of the south west, we selected emergency medicine and the rest of the specialties are from within a single (albeit very large) school – medicine (the physicianly specialties).

Specialty medical training in the south west is overseen by two schools of medicine in Severn and Peninsula. The exception is respiratory medicine, which runs a single training programme across the region. The advantage of focusing on a single school (medicine) is that we were able to compare approaches to quality management across Severn and Peninsula. It also allowed us to explore some specialties that we haven't looked at before in our regional reviews: acute internal medicine, cardiology and gastroenterology. We extended our selection of specialties to include emergency medicine so that our focus didn't become too narrow.

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

- Undergraduate
- Foundation
- Core medical training
- Medicine – acute internal medicine, cardiology, gastroenterology and respiratory medicine
- Emergency medicine

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 information, before our visit, to help inform our decisions on areas to explore during the review.

## Regional themes

There are four medical schools in the south west. This enabled us to gather a broad range of information in regard to the themes around undergraduate education in the region. The overwhelming majority of students we met were happy with their course and would recommend their medical school to others. Students spoke in positive terms about the wealth of experience they gained through the range of clinical placements at the LEPs. The medical schools are responsive to feedback and continue to make improvements based on feedback from medical students.

Likewise, the majority of doctors in training would recommend their post to another, even those in areas of high service pressure. The LEPs felt supported by both the medical schools and HEE SW. There were examples of innovation being supported in the trusts such as learners having good access to technology enhanced and simulation-based learning opportunities.

We identified several areas that are working well across the region. The learning environment in the south west values education and training, medical students and doctors in training are well supervised and generally educators are supported in their roles. Clinical, educational and pastoral support for medical students and doctors in training is good and generally working well across the region. Trainers are committed to their roles as educators and time in job plans was evidenced.

We also identified areas for improvement across the region. We found that there are service pressures in some LEPs, that there are issues with the recruitment and retention of doctors in training and consultants and that staffing levels are affecting education and training. There was evidence that in some areas the clinical learning environment is over populated by learners resulting in a compromised learning experience for medical students and doctors in training.

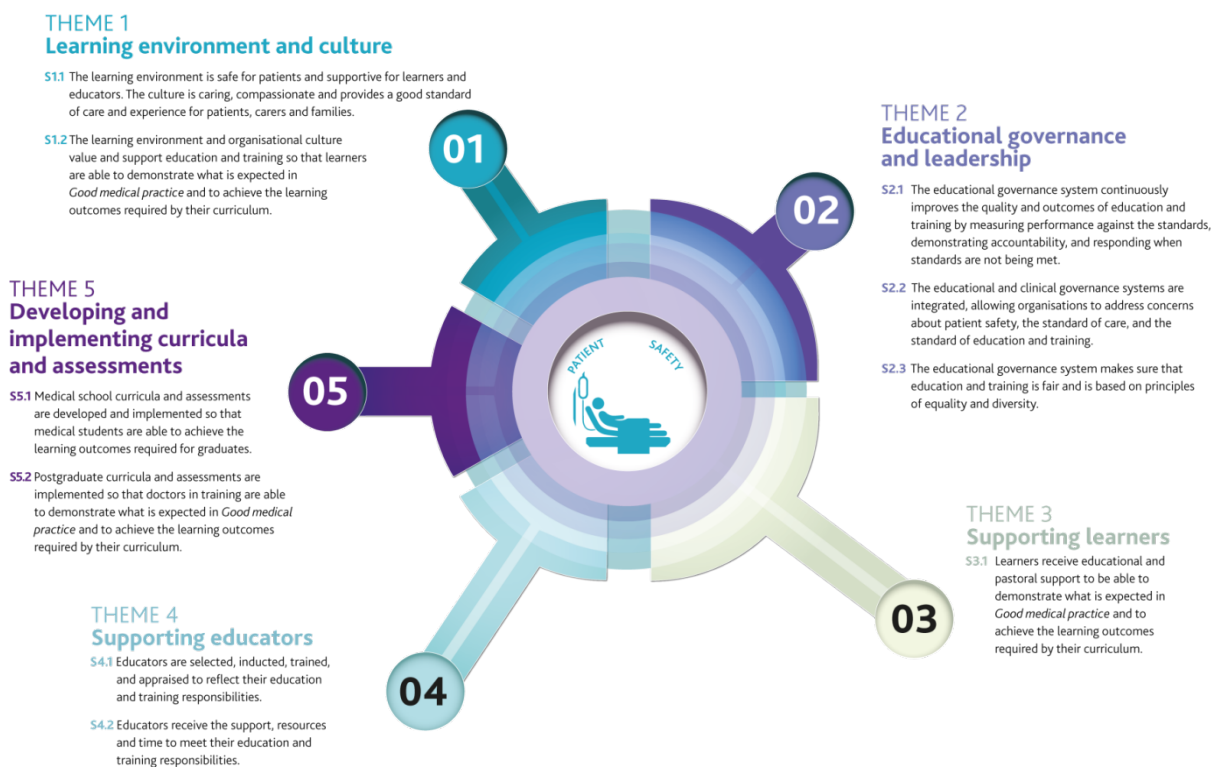
Educational governance and oversight at LEP board level was working well in some areas but found to be lacking at some sites. All LEPs in the region need to make sure education and training is adequately represented at board level. We also found that quality processes would benefit from a more integrated approach across schools, between LEPs and HEE SW, between LEPs and medical schools and between HEE SW and medical schools using the same environment.

While we heard that the presence of non-training grade doctors is mostly beneficial, in some places we heard they are having a negative impact on the education and training of the regulated groups. Any adverse educational impact that non-training grade junior doctors may have on doctors in training posts should be monitored.

Finally, in core medical training (CMT) and some of the higher medical specialties we found issues in curricula delivery with learners at risk of failing to achieve all their curricular targets. We also heard concerns about general internal medicine training across the region.

Overall, this regional report is positive and we identified no serious concerns during our visits to the different organisations. We were pleased to see that, where aspects appeared to not be working as well, the LEPs, medical schools and HEE SW were moving in the right direction to improve medical education in the locality and for the betterment of students and doctors in training.

The purpose of a regional review is to provide assurance against our standards of how medical education and training is quality managed 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*.



# THEME 1

## Learning environment and culture

**S1.1** The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

**S1.2** The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.



We came across a positive learning environment and culture at all of the LEPs and medical schools we visited:

- We found the culture at trusts was caring and compassionate with a positive learning environment 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.
- We heard from the majority of learners and educators that they want to stay and work at the trust where they are placed. This helps to create a core stable medical workforce.
- We found that medical students get high quality clinical supervision and teaching while on placement.

We also heard about staffing levels and high service pressures and the negative impact these challenges could have on education and training, particularly the effect of increasing patient numbers on rotas and handover. The impact of increasing service demands and workload on the learning environment must continue to be actively monitored by all organisations involved in the delivery of education and training. We set requirements for trusts to make sure workload doesn't adversely affect the time available for educational activities and supervision of doctors in training.

## Rotas

For a variety of reasons, filling rotas to manage the clinical workload across the region has been challenging in certain specialties and areas. We heard of disparities in rota management across specialties and sites; some rotas work well, such as emergency medicine, and others don't work so well, such as acute internal medicine (AIM). We also regularly heard about the tension between general internal medicine (GIM) and other medical specialties and how this is affecting rotas.

### Using doctors in training to fill rota gaps

Doctors in training told us that rota gaps could adversely affect the balance between service provision and training, and we heard that doctors in training at some LEPs are not always assigned to a rota on the basis of their training needs, but primarily to provide service. They were often moved between departments in order to fill gaps in the service. Educational and clinical supervisors at these trusts confirmed that the rotas are managed to ensure patient safety – but while they may be good for continuity of care, they are less good for continuity of training.

We set requirements for these trusts to make sure their rotas allow doctors in training to meet the requirements of their curriculum and training programme.

### Educational capacity

Trusts have aimed to address the issues with rotas through the creation of non-training grade posts and exploring wider workforce solutions. In some trusts, such as Plymouth Hospitals NHS Trust, they are looking at alternatives such as physician assistants to support the medicine department and help relieve some of the service pressures.

We heard that non-training grade junior doctors make up a substantial part of the workforce across the region. Approximately 20% of doctors in training grade rotas do not hold national training numbers and are therefore not 'regulated' nor are their posts quality assured or managed by HEE SW. While we heard that their presence is often beneficial – providing support to doctors in training, and facilitating access to education – in some of the places we visited non-training grades are having a negative effect on the education and training of the regulated groups. Some of the doctors in training in approved posts advised that they are moved across departments to fill gaps in rotas and they were of the view that the non-training grade doctors are moved less often. Some of the doctors in training in approved posts also felt that non-training grade junior doctors are receiving preferential access to training opportunities, such as simulation facilities and outpatient clinics.

We set recommendations for these trusts to make sure they monitor and manage any adverse effect that non-training grade junior doctors and other healthcare professionals may have on the education and training of doctors in training and medical students.

## **Case study: Introduction of physician associates at Plymouth Hospitals NHS Trust**

Plymouth Hospitals NHS Trust, in conjunction with PU PSMD, is training physician associates who are due to start working at Derriford Hospital in early 2017. We heard that inclusion of physician associates in the workforce is mostly beneficial – for example, doctors in CMT supported the introduction of physician associates to help address workload issues.

However, the clinical and educational supervisors told us they did not feel equipped to supervise physician associates. In their view, there are not sufficient resources or infrastructure in place, and although they supported the development of physician associates to help with workforce and workload issues, there is limited capacity to provide them with adequate experience or support while on placements.

Medical students from PCMD and PU PSMD were also aware of the tension in educational capacity due to the training provision for physician associates. They told us they have had only limited interaction with them and wanted to learn more about what they do and which tasks they are responsible for. There is little interdisciplinary interaction and no joint teaching. We heard about tension in the medical assessment unit where medical students thought physician associates had more access to ward rounds than they did. Foundation doctors also reported a lack of clarity and that they would like to learn more about the role of physician associates.

We set a recommendation for the trust to monitor and manage any adverse effect that physician associates may have on the education of doctors in training and medical students.

HEE SW told us that the trusts manage non-training grade junior doctors but that the issue is also being monitored by HEE SW. HEE SW is looking at the impact of these doctors on the regulated groups' quality of training, but the feedback they've obtained so far has been that the positives outweigh the negatives. We set a requirement for HEE SW to work with the LEPs to manage any adverse educational impact that non-training grades may have on doctors in approved and regulated training posts. In places where non-training grade junior doctors are either supervising or providing education for doctors in training in approved posts, the quality of the supervision and training they are delivering should also be monitored, and set in the context of the recognition of trainers.

### **Addressing resourcing issues**

Generally, we found that, during our visits to LEPs across the region, access to educational resources and facilities is adequate. But we did hear some concerns about capacity at trusts across the region during our visits to both medical schools and LEPs.

During our medical school visits, we heard that some students feel there are a lot of students on placement at one time, which can result in competition for learning opportunities. Some clinical teachers corroborated this view and said they felt they are at capacity. Some clinical staff at the LEPs we visited indicated that their capacity to deliver education is stretched, as it is a challenge to supply teaching and experience across the different groups of learners in the clinical environment: medical students, doctors in training, non-training grade junior doctors and physician associates.

As we found, in some areas, the clinical learning environment is over populated by learners, which potentially compromises the learning experience for medical students and doctors in training, we set a requirement for HEE SW to work with LEPs and medical schools across the region to maintain oversight and management of educational capacity.

## Handover

During our visits to LEPs across the region, we found that handover varies between trusts, departments and specialties, with some noting that handover works adequately, while others said it is not effective and often lacks educational value. In particular, handover between different departments appeared to be problematic as opposed to handover between shifts. We are concerned about the interface and handover between different departments posing a potential risk to patient safety at some trusts.

We set requirements for these trusts to review handover procedures between departments to make sure all handovers take place effectively and consistently to avoid any risk to patient care. We acknowledge that care pathways differ between sites and we acknowledge there are various safety measures linked to the handover of patients. But we encourage HEE SW to work with sites that are experiencing issues with the handover of patients.

## **Case study: Handover between the emergency departments and medicine departments at Gloucestershire Hospitals NHS Foundation Trust**

We found that the current system of handover at Gloucestershire Hospitals NHS Foundation Trust and the interface between the emergency departments and the rest of the hospital could pose a potential risk to patient safety. The emergency department at Cheltenham General Hospital closes at 10 pm and patients may be moved to other departments or referred to the emergency department at Gloucester Royal Hospital. This closure at Cheltenham General Hospital has affected the workload in the emergency department at Gloucester Royal Hospital, where patients may be moved to other departments due to limited availability of beds.

We heard from senior management at the trust, that there are various safety measures linked to the handover of patients from the emergency department to the medicine department. The senior management team told us the patients who are transferred are logged into the trust's electronic system. At Cheltenham General Hospital, the ambulance services stop bringing in patients at 8 pm – but the emergency department consultants work until 10 pm and have a detailed handover with the medical registrar. This handover involves a plan of treatment for all patients that are being transferred from the emergency department. Senior managers said the above handover procedure for transfers of patients between departments is also followed at Gloucestershire Royal Hospital.

However, doctors in training said the handover between the late shift consultant in emergency department and the medical registrar does not always take place. Sometimes a bed request is put on the system without a detailed reason for referral. Doctors in training reported issues with the electronic system (Patients First), which has caused issues with tracing patients as well as the provision of appropriate care.

### **A potential risk to patient safety**

We asked doctors in training if they had any examples of occasions when patient safety had been compromised, but we were told that although there had been no such cases, there had been instances of 'near misses'. Sometimes patients have been transferred to medicine wards with an incomplete diagnosis and this delayed treatment. Doctors in training have raised this issue with their supervisors and trust management. The trainers we met also acknowledged the issue with the transfer of patients between emergency departments to medicine wards. Doctors in training emphasised the need for medical gatekeeping and improving the communications between departments on interdepartmental transfers of patients.

We set a requirement for Gloucestershire Hospitals NHS Foundation Trust to make sure there is a robust handover system between the emergency departments and medicine departments in both hospitals to avoid any adverse impact on patient care.

## Simulation

We heard about learners having good access to technology enhanced and simulation-based learning opportunities in the region. Students studying at PCMD told us they have good access to these types of learning opportunities and we were impressed with the involvement of undergraduate students in the simulation sessions with foundation doctors at trusts. Students felt that this simulation training would help prepare them for the foundation programme. Another example is Royal Cornwall Hospital, which has embedded multi-professional simulated and human factors training for undergraduate and postgraduate learners – we have cited this as an example of good practice.

### **Case study: Simulation training at Royal Cornwall Hospitals NHS Trust**

We heard that a recent successful bid for HEE SW innovation funding has led to the establishment of a core team, based within postgraduate education, which has developed human factors training at Royal Cornwall Hospital. The trust has a dedicated simulation practitioner and a simulation fellow managing an ongoing programme of multi-professional learning. The simulation team told us the environments feel more real, and that it has been used to help identify and address the weaknesses, including human factors, which have contributed to past adverse events to assist with patient safety and quality improvement.

We found that simulation training is embedded and used positively by the trust. Medical students and doctors in training we spoke to told us that simulation contributed positively towards training. We also heard that the trust uses simulation training before it puts any new system in place – so the system can be tested first in a controlled environment.

The trust has 35 simulation scenarios, which have been created to fit with the nursing and medical curricula. There are also some bespoke programmes. Each simulation session has a curriculum-based scenario. The simulation team told us that after a simulation scenario, a report is generated and sent to the relevant clinical governance team to help that team make changes within the trust. Feedback is also collated following simulations and entered into a simulation database.

## THEME 2

# Educational governance and leadership



- S2.1** The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.
- S2.2** The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.
- S2.3** The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

One of the requirements under theme 2 of [Promoting excellence: standards for medical education and training](#) says 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 that are responsive to feedback from learners and educators. We were impressed at how well the disaggregation of PCMD is being managed.
- At some 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 that undergraduate and postgraduate education and training are properly considered at board level.
- At other trusts, we came across a lack of awareness around important educational issues, such as CMT doctors in training not being able to attend teaching, or the requirements for recognition of trainers.

- We set requirements for these trusts to ensure improvement in the following areas:
  - To clearly demonstrate accountability for educational governance at board level, to make sure educational and clinical governance are integrated effectively, and to make sure issues that relate to education and training are appropriately represented, as this affects patient safety and delivery of care.
  - To make sure educational governance systems and processes to control the quality of medical education and training are clearly understood by educators and learners. Educational governance systems must also demonstrate board level oversight.
  - To review educational governance systems and processes to make sure improvements to education and training are embedded and sustained.
- We have urged HEE SW to work with LEPs to make sure local educational governance is improved across the region by sharing good practice from sites where educational governance is well-sighted at board level.

### **Case study: Educational governance at University Hospitals Bristol NHS Foundation Trust**

The trust board at University Hospitals Bristol NHS Foundation Trust demonstrates strong accountability for educational governance. This means that both undergraduate and postgraduate education and training are properly considered at board level.

The board at the trust is fully engaged in managing medical education. Education managers are well represented at board level and there is a clear interrelationship between the director of medical education and the executive directors of the trust. Senior managers told us that they put a great deal of effort into integrating their educational governance systems throughout the trust, and make sure that medical education features in their fortnightly business and strategic meetings.

Senior managers told us that the board is well informed about all aspects of education, including progression. There are clear structures in place to monitor quality at every level, and accountability sits with the board. The director of medical education sits on the senior leadership team and regularly introduces medical education items on the agenda to be discussed. There is also a junior doctor committee with representatives from each of BMS's areas; in their meetings they discuss education concerns and monitor quality.

## Equality and diversity

During our visits, we found the collation of equality and diversity data on doctors in training or trainers is not uniformly thorough. Moreover, any data that are collated are not analysed in sufficient detail and often, education management teams were unsure about how they could use these data effectively. Issues can arise from this lack of analysis of the protected characteristics of doctors in training and trainers with potential for significant impact on a doctor in training's experience and progress. Without either the use of existing data or the collection of data by the education departments, there is a risk that differential experience and achievement may be overlooked.

There seemed to be a heavy reliance on data provided by HEE SW and the GMC. HEE SW runs a local survey, which informs the LEPs of areas that are working well and those that are not. We found that data collection tends to be reactive rather than proactive in informing changes to education and training. There is scope to improve the LEPs' collection of data generally, and their use of equality and diversity data in particular, to monitor progression and make sure the delivery of training is fair.

### **Equality and diversity is working well at the medical schools and some of the LEPs we visited**

We heard that the patient population in the south west has little social, cultural and ethnic diversity – so learners may not come across the same diversity of patients as they might in other areas of the UK. Medical students have had talks on equality and diversity and there are often teaching opportunities in outpatient clinics when they are able to discuss diversity and its influence on health with different patient groups.

PU PSMD demonstrated an effective approach to their collection and use of equality and diversity data. We heard that ethnicity, disability and gender data is looked at in detail for all summative assessments: the school groups assessments to see if the protected characteristics have any effect on progression. There is a clear policy and threshold for action should significant concerns arise, including a review of the support provided. We were told that, through these steps, the school identified that assessment practices varied in different localities, and have been able to put changes in place accordingly.

At UEMS, students told us that the lack of a culturally and ethnically diverse population in the area is being addressed with the use of clinical scenarios within their problem-based learning teaching. We heard these scenarios encompass a variety of patients from different cultural and ethnic backgrounds. We also heard that students have opportunities to gain knowledge and understanding of the needs of patients from diverse social backgrounds.

PCMD students are learning about the needs of patients from diverse backgrounds through lectures and small-group teaching. We heard the demographic of the region is changing with Plymouth becoming a dispersal city for asylum seekers. We were told that

students are also given a wide range of GP placements to increase the variety of patient groups they have contact with, such as migrant workers and the travelling community.

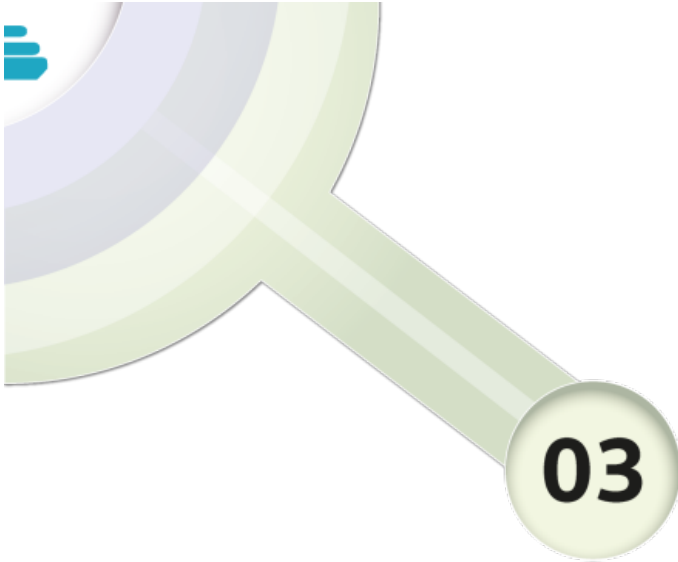
Lastly, Royal Devon and Exeter NHS Foundation Trust is working with local schools to encourage wider access to the medical profession, and we have cited this as an example of good practice.

### **Case study: The medical work experience programme at Royal Devon and Exeter NHS Foundation Trust**

We were impressed with the medical work experience programme, which Royal Devon and Exeter NHS Foundation Trust operates to help widen access to the medical profession. The programme runs annually and supports around 70 students who are interested in studying medicine. This includes lectures from doctors in a wide variety of medical specialties, including general practice, to give them an idea of the scope and breadth of being a doctor. Participants can also attend clinical placements with consultant medical staff in the hospital in a variety of clinical settings and are given support when they apply for medical school.

The trust also delivers broader community-facing experiences, as recommended by HEE's Broadening the Foundation Programme.\* The senior management team explained that when it reviews placements, it also considers the Broadening the Foundation Programme's recommendation for broader community-facing experiences. We heard that placements in educationally poorly performing hospitals are being replaced by community-based placements.

\* You can find out more about HEE's Broadening the Foundation Programme on HEE's website at: [www.hee.nhs.uk/our-work/hospitals-primary-community-care/learning-be-safer/better-training-better-care-btbc/broadening-foundation-programme](http://www.hee.nhs.uk/our-work/hospitals-primary-community-care/learning-be-safer/better-training-better-care-btbc/broadening-foundation-programme).



## THEME 3 Supporting learners

**S3.1** Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

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.

- Medical students reported that they value the level of help and support given to them by the trust administrative staff and that the local medical school offices at LEPs enables medical students to easily access educational and pastoral support.
- Most doctors in training and medical students we spoke with told us that they receive appropriate support from the trust they have placements with and they would recommend the post.
- There is a strong system of academic support at the medical schools. We heard that the learning environment values education allowing students to achieve their learning outcomes.
- We were pleased to hear about PCMD continuing to support and address the needs of students throughout the teach-through period to make sure their education is not adversely affected by the disaggregation.
- At BMS, we were impressed with the Learning in The Hospital Environment Programme (LiTHE), which bridges the transition between pre-clinical and clinical learning. We have cited this as an example of good practice.

### **Case study: LiTHE unit at Bristol Medical School**

Prior to our visit, BMS told us about the recent introduction of the Learning in the Hospital Environment (LiTHE) unit, which takes place at the end of year 2. This unit marks the beginning of clinical medicine and aims to bridge the transition between pre-clinical lecture-based learning and clinical ward-based learning. BMS developed the unit in response to challenges that students had raised and is a four-week NHS-based course, which takes place in the university academies across the region.

The vast majority of students who responded to our pre-visit student survey agreed that the course teaches them the connections between basic science and clinical practice. During our visit, most of the year 3, 4 and 5 students confirmed this by stating they were supported during the transition from pre-clinical to clinical learning and they spoke highly of the LiTHE module. They added that there is a strong patient safety focus and that inter-professional learning begins in this unit.

## **The Professional Support Unit**

The Professional Support Unit (PSU) was created to help support doctors in training who were experiencing some form of difficulty by enabling them to access consistent, expert advice when needed. When a doctor in training is identified as being in difficulty at a LEP, the LEP can refer them to the PSU for further support. The PSU can provide resources, such as counsellors, study skills, language specialists or occupational health services. This approach has been successful because HEE SW has been able to formalise the support it offers to doctors in training using careful, individually-tailored resources to help them through challenging times.

At the time we visited HEE SW, the PSU was managing 105 doctors in difficulty; 55% were self-referrals. We were pleased to hear that the PSU actively seeks feedback about its services, which has so far been positive. In the near future, HEE SW plans to carry out a longitudinal analysis to address efficacy of the service.

### **A good service, but awareness must improve**

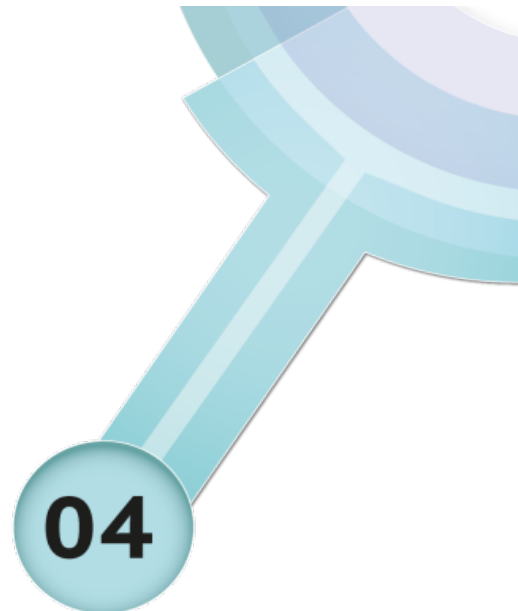
We commend the work of HEE SW's PSU and the careers advice service. However, we found a lack of awareness among the doctors in training we spoke to at the LEPs about the PSU as a support mechanism for them. We encourage HEE SW to promote the work of the PSU throughout the region.

We heard that the interface with HEE SW undergraduate careers service is developing and HEE SW works closely with some medical schools in the region, as they encourage students to be proactive with their career planning.

## THEME 4 Supporting educators

**S4.1** Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.

**S4.2** Educators receive the support, resources and time to meet their education and training responsibilities.



We came across a supportive environment for educators at all of the LEPs and medical schools we visited.

- Educators at medical schools receive the resources to support their educational roles, including clear educational requirements and structures for teaching from the medical schools.
- Clinical teachers for medical students get appropriate inductions and training for their roles.
- Academic teachers for medical students get excellent support for development, enabling them to meet their training needs.
- Clinical and educational supervisors appeared to be well supported in their educational roles by the trusts. They have adequate facilities, are selected, trained and funded adequately, and are encouraged to continue their professional development.
- We heard that the LEPs in general value their educators and that trainers have enough time in their job plans to meet their educational responsibilities.
- HEE SW runs a centralised training programme for the faculty development of educational and clinical supervisors in the region. See: [www.severndeanery.nhs.uk/about-us/education-and-training/educational-supervisors-core-accreditation-requirements/](http://www.severndeanery.nhs.uk/about-us/education-and-training/educational-supervisors-core-accreditation-requirements/).

## Time allocated in job plans for education

HEE SW has worked with the LEPs to outline what is expected of them in their clinical supervision role and to make sure supporting professional activities (SPA) time is properly deployed in job plans.

Although we heard at the LEPs that educational and clinical supervisors have sufficient time in their job plans for their educational commitments, staffing levels and high service pressures prevented them from making best use of their allocated time, so it is not always being delivered in practice. We heard that, in many cases, supervisors continue to support doctors in training through their own goodwill and commitment, despite service pressures.

We set requirements for trusts to make sure workload does not adversely affect the time available for educational activities and supervision of doctors in training.

## THEME 5

# Developing and implementing curricula and assessments



**S5.1** Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

**S5.2** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

- We found that medical student placements at the LEPs are delivering good coverage of the undergraduate curriculum. Medical students receive good practical experience and structured teaching at the trusts with good access to the clinical environment.
- We came across some inconsistencies in the assessments run by medical schools. We set a requirement for BMS to improve the reliability of its long case clinical assessments and set requirements for PCMD, UEMS and PU PSMD to review how on the spot judgements are used, how they communicate their educational validity to students and to make sure students and educators clearly understand how professionalism is assessed.

## High service pressures and the effect on education and training

Major service delivery challenges are common among the LEPs – particularly around finances, workload and staffing. Across the six LEPs we visited, we found that the increasing workload leads to difficulties in simultaneously meeting service pressures while also ensuring good quality education and training. Service pressures affect learning opportunities in two major ways: by reducing opportunities for on the job learning in wards, clinics and theatres; and by decreasing the time available for doctors in training to attend formal teaching. The effects of service delivery demands on education and training differed in the various trusts. Overall, CMT was the most affected programme by the increasing workload.

### **Case study: The effect of an increasing workload on core medical training in University Hospitals Bristol NHS Foundation Trust**

Doctors training in core medicine at University Hospitals Bristol NHS Foundation Trust told us that access to local and regional teaching is limited due to service pressures. They thought there is a greater focus on service provision rather than on education. Doctors in core medical training have to attend at least 70% of their teaching to meet the requirements of their annual review of competence progression (ARCP), but this is clearly a struggle for some doctors. Senior managers said that they try to track when doctors in training cannot attend their training.

Doctors in core medical training told us that they are finding it difficult to access the outpatient clinics they need to meet their training requirements. Educational supervisors are aware of the competences that doctors in training must meet and they feel that, even though doctors in core medical training may find it difficult to access clinics, this does not affect their progression through training. Senior managers stated that there have been few issues with or differences in the achievement of doctors in training on an annual basis.

- On our visits to LEPs across the region, we found an imbalance between providing service and accessing educational and training opportunities. Doctors in CMT said there is limited access to local and regional teaching due to service pressures. CMT doctors also told us they are finding it difficult to access the clinics they need to meet their training requirements.
- We set requirements for trusts to make sure all doctors in CMT are released for mandatory training sessions and outpatient clinics so they can meet the required curriculum outcomes.
- We also heard of similar problems in some of the higher medical specialties – particularly in cardiology and gastroenterology where doctors in training find the specialty specific teaching useful but are frustrated that service pressures are preventing them from attending.
- Some doctors in training said they alleviate this pressure by using discretionary time and time out of programme to attend clinics and achieve their targets.
- In addition to the issues with CMT and higher specialties mentioned above, our visits to LEPs across the region highlighted inconsistencies in the delivery of structured general internal medicine (GIM) training. At some sites, doctors training

in GIM feel that they don't get enough regional training days and that they are poorly organised. We also heard that workload commitments are high, which results in doctors in training not being able to meet their curricula requirements, attend timetabled teaching or have adequate access to educational opportunities.

- We set a requirement for HEE SW to make sure the delivery of training in GIM is structured and consistent across the region.

## What next for the south west?

Following our visits to HEE SW, BMS, UEMS and PU PSMD, we've set requirements and recommendations for each organisation in our detailed visit reports ([www.gmc-uk.org/education/26814.asp](http://www.gmc-uk.org/education/26814.asp)). They will update us on their progress towards meeting these requirements and recommendations through scheduled reports. HEE SW will also monitor and report updates on the requirements and recommendations from the LEP visits.

We'll also look at how to share the areas of good practice with other education and training providers – we have already begun this by hosting a regional day in October 2016, to which we invited representatives from HEE SW and all medical schools and LEPs in the south west region.

We'll continue to support all our stakeholders in the south 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'll also take our learning from this review and apply it to our regional review of east midlands and our national reviews of Northern Ireland and Scotland, which are scheduled for 2016–17.

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