
Review of training in Audio vestibular medicine

Introduction

Our established quality assurance processes that we have in place for larger specialties are being extended to allow us greater insight into the quality of training for small specialties. However, we are aware that there are specific challenges for doctors in training in these specialties, their trainers, educational and clinical supervisors, and for local education and training boards (LETBs) and deaneries in quality managing the trainee experience and its outcomes.

By small specialties, we mean those with fewer than 250 current doctors in training in post or those where, in order to protect the identity of the doctors in training concerned, we are unable to publish deanery-level trainee survey results for more than 10% of that specialty's training programmes, due to the low number of doctors in training.

We are looking to fill potential gaps in our evidence base about the quality of training in these specialties. The review of small specialties aims to provide assurance to us (as the regulator), the public, and delivery partners about the quality of training in small specialties in the UK by ensuring compliance with our standards for postgraduate training as outlined in [The Trainee Doctor](#) (pdf).

We are focussing on the delivery of postgraduate education within the specialty and to consider the policies, processes and systems in place to support this. The review aims to encourage improvement of the training experience and outcomes, share good practice and show the importance and benefits of effective training pathways.

Background

In the latter half of 2014 we reviewed Audio vestibular medicine* (AVM). We met the lead dean for the specialty and specialty and college representatives. We visited London and the North West and spoke with doctors in training and trainers from both regions. We met the training programme director at each location and the Health Education North West (HENW) Dean and specialty lead Associate Dean. We also consulted with the Joint Royal Colleges of Physicians Training Board (JRCPTB).

Our evidence base for Audio vestibular medicine (AVM) is limited, but includes data from the following sources:

- the national training survey (NTS)
- annual review of competence progression (ARCP) outcomes
- biannual reports from deaneries and local education and training boards (LETBs)
- annual reports from the JRCPTB

Joint Royal Colleges of Physicians Training Board

The JRCPTB is a Federation of the Royal Colleges of Physicians within the UK and is the body responsible for setting and maintaining standards for physician specialist training in the UK.

Audio vestibular medicine is one of 33 specialties or sub-specialties that sit under the JRCPTB. A Specialty Advisory Committee (SAC) sets curricula and assessment systems, and assists and supports local programmes to manage and improve the quality of education across each specialty.

Each SAC draws together expert educators from across the UK and is comprised of leading consultants, doctors in training and lay representatives. Training Programme Directors (TPDs) are often members of the SAC.

The JRCPTB and the SAC are tasked with the following activities:

- annual review of the curriculum and assessment systems
- production of an annual specialty report (ASR) submitted to the GMC
- provision of advice during LETB and deanery visits to local education providers; of external advice on ARCP panels; and advice and support for new training posts and programmes
- recommendation of doctors in training eligible for CCT or CESR.

* The name is listed as two words in legislation: http://www.gmc-uk.org/Postgraduate_Medical_Education_Training_Amendment_Order_of_Council_2012_No_344.pdf 48221939.pdf . The specialty is looking into having the name changed in legislation to one word only (Audiovestibular medicine).

Summary of findings

1. Training in AVM is provided in two locations in the UK, in London and HENW. There are currently 13 doctors in training in the specialty, 10 based in London and three based in the North West.
2. The team found that the training was overall fit for purpose. Doctors in training and trainers were committed to the specialty and the SAC Chair was enthusiastic and very committed to developing training and delivering improvements in the specialty. We found that the SAC responded proactively to concerns raised about training and achieved positive results. For example, training and conferences had been organised to raise awareness in the specialty around bullying and undermining.
3. Based on what the team heard when speaking with a range of people involved in AVM training in the UK we found both training programmes to be well managed and delivered. Highly motivated trainers are working within the specialty and are having a positive impact. Trainers, doctors in training and leaders in the specialty recognise that there are challenges (for example long distance secondments in either Derby or Cardiff under the North West training programme) but these appeared to be effectively managed and monitored. Some variation is expected by doctors in training but the overall consensus was access to high quality clinical training. On the whole we also found that doctors in training were well supervised clinically and educationally.
4. Clinical and educational supervisors appeared to be well supported in their roles. The specialty fostered robust training to become trainers, including the completion of accredited courses leading to a qualification.
5. We found that not all trainers had time identified in their job plans for education. We also found that some trainers and doctors in training needed more support in raising concerns about others' practice in such a small specialty and that some doctors in training needed guidance and reassurance on how they would be supported if concerns were raised about their own progress.
6. As part of the review we identified examples of effective practice that we encourage (see good practice section) and challenges and opportunities for improvement (see requirements and recommendations section).

Areas of good practice

We generally note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further.

Number	Paragraph in <i>The Trainee Doctor</i>	Areas of good practice
1	6.16, 6.34, 6.35	Training for trainers is provided in every location, and we found that there are some very good courses aimed at ST5 doctors in training to develop them to the level of a clinical supervisor. Attendance at these courses is encouraged. (paragraph 56).
2	5.2	Training was individually tailored towards the needs of each doctor in training. Rotations for the following year of training were constructed to target any gaps in experience identified at ARCP for each doctor in training. The bespoke nature of training was only possible due to small numbers in the specialty. (paragraph 29)
3		We were pleased to hear that preparation for the GMC's scheme on the recognition and approval of trainers was reported to be on track for the specialty. (paragraph 59).

Requirements

We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards. If these requirements are not met, we can begin to withdraw approval.

Number	Paragraph in <i>The Trainee Doctor</i>	Requirements for the LETB/School
1	8.4, 6.21, 6.3, 8.5 sd 2.2	<p>London LETBs and HENW must ensure that all staff with responsibility for educational and clinical supervision have:</p> <ul style="list-style-type: none"> • allocated time for education in their job plans • support, guidance and advice to recognise and manage doctors in difficulty at an early stage • support to effectively use tools for educational supervision, such as online workplace based assessment approaches and a benchmarking system to promote consistency when completing the assessments. <p>(recommendation 11 and paragraphs 5, 49 and 58).</p>

Recommendations

We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas in line with best practice.

Number	Paragraph in <i>The Trainee Doctor</i>	Recommendations
1		<p>Service and education providers should assess whether the specialty is required in all four geographical areas of HEE and NHSE.</p> <p>The specialty is facing losing a third of its workforce in the next few years due to consultants retiring and not enough doctors in training being</p>

		recruited in England. If the commissioning of AV services is supported by all four geographies, considerations will need to be given to the additional training requirements needed to deliver the service (paragraphs 12 and 14).
2	5.2	<p>A mapping exercise to the curriculum should be undertaken for every post in the country, particularly the secondments in Derby and Cardiff under HENW, to justify the rotations and collection of posts that make up the training programme.</p> <p>It would then be evident where doctors in training need to go for training and why. It would also ensure that TPDs and trainers had information about coverage nationally and could take action to ensure doctors in training were able to fill in experience and training gaps (paragraph 32).</p>
3	6.2	<p>Greater clarity and guidance should be given to doctors in training on what evidence is required at ARCP and the Penultimate Year Assessment. The mapping exercise to the curriculum on the experience expected from each post and secondment would help to clarify ARCP requirements and reduce variability and inconsistency amongst trainers in how they sign off ARCPs.</p> <p>(recommendation 2 and paragraph 33)</p>
4	6.9	<p>The form doctors in training complete when applying for secondments should be reviewed to reduce variation in how information is recorded and to integrate the form into the e-portfolio system more easily (paragraph 30).</p>
5	Sd 3.2	<p>The specialty should pursue and roll out its plans to build knowledge based assessment into the curriculum so that it is no longer dependent on University College London to deliver the assessment system (paragraphs 45 and 46).</p>

6	Sd 3.2	The specialty should continue to review the MSc and explore alternative ways of assessing the knowledge and competence of AVM doctors in training (paragraph 47).
7	5.20	The specialty should review some of the workplace based assessments currently in place to reduce the assessments in length and reduce administrative burden (paragraph 48).
8		The current requirement of the curriculum to undertake one MSF exercise every year and to obtain feedback from 12 people is proving difficult for doctors in training and this should be reviewed (paragraph 50).
9	5.2-5.4	The specialty should ensure trainers fulfil their responsibility for building the confidence and competence of doctors in training in management and leadership by promoting available courses and learning in the workplace. Development of leadership and management capability is included in the AVM specialty curriculum. The specialty may wish to explore the introduction of structured assessments in this area into the curriculum (paragraph 51).
10	2.3	The specialty should pursue its plans to introduce patient feedback forms into the specialty to raise awareness amongst consultants and doctors in training of what patients expect from them. The specialty may wish to look into the forms being included in the curriculum so that feedback from patients features in training (paragraph 52).
11	6.30, 6.34-6.35	Sessions for trainers should be included in training days on dealing with challenging situations, including the management of doctors who require additional support (requirement 1 and paragraph 5).

12	Sd 2.1-21.2	The London LETBs and HENW should ensure that there are clear processes and support mechanisms in place so that doctors in training know they will be supported if concerns are raised about their progress or they experience issues during their training. Doctors in training should feel confident that they will be supported if they raise concerns (paragraph 5).
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Findings

7. From the evidence we reviewed and the people we spoke to, we heard that doctors in training are mostly satisfied with the quality of their training and their ability to demonstrate the required levels of competences. This report focuses on highlighting a number of key themes across the UK where we heard concerns, where there is room for improvement and where issues are being effectively identified and addressed.

Patient safety and raising concerns

8. AVM is a relatively low risk specialty with services delivered mostly in non-acute settings, and staff are therefore unlikely to come across any serious patient safety issues. We did not hear anything that identified immediate patient safety concerns in AVM training in the areas we visited. Nor did we hear that there were any concerns about doctors in training working beyond their competence. Doctors in training reported a good work-life balance compared to other specialties as there is no out of hours work. They were able to work within their hours as most of the work was elective, and they hardly ever had any emergency work to contend with.
9. We did hear scepticism from some doctors in training about the usefulness of raising concerns through the NTS because of the small numbers and subsequent constraints on reporting where there are fewer than three doctors training at one site. Fear of being identified or comments having a negative impact on training and career progress was a disincentive to be forthcoming with information, or even to fill in the survey. This wariness about raising concerns and worry about how proportionate and balanced any reaction would be was also said to be a barrier to raising any issues locally.
10. No concerns around bullying and undermining were raised through this review. We understand there were issues previously that have already been addressed through mechanisms such as training and conferences, to raise awareness in the specialty around bullying and undermining.

Governance, management and improvement

11. In meetings with college and specialty representatives, the Lead Dean, HENW Dean and during visits to London and the North West we were satisfied that there are structures and processes in place to manage the specialty regionally and across the UK. The TPDs in both regions that we visited were committed and their expertise and management of training within each of the regions was highly valued.
12. The specialty overlaps with other areas such as audiology and otolaryngology, known more familiarly as Ear, Nose and Throat (ENT) surgery. Both the SAC and Lead Dean observed reluctance amongst Trusts to replace AVM consultants when they leave or retire and that increasingly, aspects of adult AVM that fall outside of general medical and neurological conditions were being covered by ENT surgeons and audiological scientists. The specialty is facing losing a third of its workforce in the next few years due to consultants retiring.
13. The specialty will need to think carefully about how to ensure momentum is maintained and new leaders are developed nationally and regionally when the

current SAC chair and two TPDs complete their terms of office, especially considering the impending loss in consultant numbers.

14. The North West Dean and TPD thought it advisable to enquire about the commissioning of services with Health Education England (HEE) and NHS England (NHSE). As not enough doctors in training are being recruited into the specialty, it would be worth approaching both organisations for their input on whether AVM is required in all four geographical areas: North, Midlands, London and KSS, Southern. If clarification is provided on the number of AVM posts available then it would be easier to work out how to distribute training accordingly. If NHSE supports commissioning AV services in all four geographies then HEE may wish to consider what additional training requirements are needed to deliver the service.
15. We support and encourage multi-professional and collaborative working across the AVM and ENT specialties and with audiological scientists to manage the overlapping areas with uniformity and deliver the best patient care. It was reassuring to hear that attendance at multi-disciplinary team meetings by consultants and doctors in training was strongly encouraged in the specialty.

Equality, diversity and opportunity

16. There was consensus among doctors in training and trainers about the important role equality and diversity plays in the specialty, and no concerns were raised in this area. Some of the consultants we spoke to commented that equality across the specialty is easier to achieve with such small numbers. Two out of the three trainees in the North West were training less than full-time and reported it to be well supported except for current inflexibility around the Diploma and MSc courses.

Training structure and content

17. Audiological medicine was officially recognised as a specialty in 1975 and the name was changed in 2012 to Audio vestibular medicine to better reflect the scope of work. The specialty was formed to address the complexity of hearing and balance disorders and to bring together specialists in the field to enhance patient care. The specialty involves the diagnosis and medical management of hearing and balance disorders in both adults and children. This includes hearing difficulties, tinnitus, vertigo and imbalance. There is an additional speciality interest in the medical diagnosis of children with developmental disorders of speech.
18. Although as specialties both Audio vestibular medicine and Otology (part of ENT surgery) see patients with the same problems the approach is different and the two specialities are complementary. On average, an Audio vestibular physician consults with six patients in the time ENT surgeons consult with twenty patients. Audio vestibular physicians take a more holistic approach than ENT surgeons and look at the underlying medical problems. Consequently the assessment of patients takes longer and is more extensive but is usually offered as a one-stop shop and addresses the problem, often without the need for medical review. Audio vestibular physicians have the training to equip them in finding root causes of dizziness and to undertake complex balance assessments that are not routinely carried out by ENT surgeons. The following document on the Royal College's website contains further

information about the specialty:

https://www.rcplondon.ac.uk/sites/default/files/audiovestibular_medicine.pdf

19. The AVM curriculum covering ST3-7 builds on skills and competencies acquired during the foundation years and two years of Core Medical Training (CMT) followed by five years of higher specialty training. The curriculum makes allowance for the fact that it is likely doctors in training may not have had any specific training or exposure to AVM on entry to ST3.
20. Entrants to AVM at ST3 level come from a variety of backgrounds such as neurology, rehabilitation medicine, general medicine, paediatrics, ENT surgery and general practice. Fundamental to the practice of AVM is a physicianly approach to the patient; this is acquired through gaining CMT, Acute Care Common Stem, or the equivalent basic training in paediatrics (ST1 to ST3) or general practice (ST1 and ST2). Doctors in training who have successfully completed core training in ENT surgery, need to acquire MRCS (ENT) which involves parts of both MRCS and DOHNS as described in the curriculum.
21. The multiple routes of entry into the specialty bring a wealth of skills and experience from a range of specialties and a diverse knowledge base. The broadened entry requirements are in line with recommendations arising from the [Shape of Training](#). A few of the clinical and educational supervisors commented that it could be challenging to work out the knowledge base of the doctors in training when they enter the AVM programme as it varied according to the specialty they came from.
22. Doctors in training and trainers appreciated the breadth of the training programme and opportunities to develop in-depth skills through the Diploma in Audio vestibular medicine and the MSc. The Diploma is part of the MSc, the Diploma consists of 120 credits and the MSc adds a research project and dissertation leading to 180 credits. We repeatedly heard that doctors in training and trainers saw value in their unique programme and both qualifications were thought to be important and added value to the specialty.
23. No concerns were raised with regard to clinical and educational supervision; trainers were perceived to be passionate, supportive and interactive with the doctors in training. Trainers were supportive of time off for courses and training. Doctors in training in the North West explained that they met with their Educational Supervisor every four months for a review of progress and received clinical supervision according to their training needs. Due to the small size of the specialty, the Educational and Clinical Supervisor tended to be the same person. Doctors in training referred to some variability and inconsistency between the consultants in how they sign off ARCPs and what evidence they ask for.
24. Three trainees were training within the North West programme at the time of this review. Sites that deliver the adult service in AVM have been decommissioned due to trainers and consultants retiring. There was no access to adult AVM training within Manchester.

25. Following the loss of AVM adult services at Central Manchester University Hospitals NHS Foundation Trust (CMFT) in September 2011, HENW pursued links held with Cardiff and Derby/Nottingham to strengthen learning opportunities in adult services. The sudden change in training locations and requirement to travel long distances to access adult AVM training was concerning and disruptive for doctors in training on the programme at the time. However, current doctors in training within the North West programme did not report the possible secondments in Cardiff and Derby/Nottingham to be a concern as it was explained to them when they enrolled on to training and they had their expectations managed. They were prepared to undertake secondments to these locations provided they receive enough advance notice.
26. Paediatric vestibular diagnostics was not undertaken to the same extent in the North West as it was in London, which had the larger volume of patients in this aspect of the specialty. Doctors in training within the North West also had to travel to London to gain experience in adult auditory processing disorders and posturography.
27. Doctors in training confirmed that they enjoyed training within the North West programme and would be disappointed if training was brought under one LETB and solely delivered in London. The TPD supported keeping the training programme running in the North West and observed that training in a variety of locations, rather than just within one Trust, provided more well-rounded exposure to the specialty.
28. The loss of CMFT as a major training site prompted HENW to conduct a review of the training programme in November 2012 (Appendix 2). We were reassured by the review undertaken locally and that the recommendations arising from the report appear to be on track.
29. Training is individually tailored towards the needs of each doctor in training. Rotations to cover the following year of training are put together to target any gaps in experience identified at ARCP. The bespoke nature of training is only possible due to small numbers in the specialty.
30. Doctors in training felt that addressing curriculum gaps was expected to be self-led but that educational supervisors and LETBs would support their needs. Educational supervisors commented that the nature of rotations provided doctors in training with the opportunity to work in a variety of settings and with different trainers. Doctors in training suggested that it would be helpful if the standardised form they complete when applying for secondments could be developed and integrated into the e-portfolio system more easily. The current form is paper based and there was reported to be wide variation in how doctors in training record secondment information.
31. Training was described as a careful balancing act between the Diploma, MSc, clinical experience and secondments. Doctors in training needed to be proactive and plan carefully how to get the required experience. This seemed to be based to a large extent on who their educational and clinical supervisors were and on

goodwill from other clinicians. Although we support doctors in training needing to be proactive, this approach appeared to result in a significant variation in access to certain training opportunities.

32. We heard concerns from doctors in training and trainers that programmes could be mapped better to the curriculum so that for those units where some experience was unavailable, the competencies that doctors in training should acquire in other posts/secondments outside the unit would be clearer. Closer mapping to the curriculum for every post in the country would help to justify the rotations and collection of posts that make up the training programme. It would then be evident where doctors in training need to go for training and why. It would also make sure that TPDs and trainers had information about coverage nationally and could take action to ensure doctors in training were able to fill in experience and training gaps.
33. Some doctors in training also reported a lack of clarity as to what evidence is required at ARCP and the Penultimate Year Assessment in particular. A mapping exercise to the curriculum on the competencies and skills expected from each post and secondment would help to clarify ARCP requirements. It should also help to improve consistency between the consultants in how they sign off ARCPs (paragraph 32).

The assessment system

34. The Diploma in Audio vestibular medicine forms the knowledge based tuition and assessment of the specialty and is mandatory for the award of CCT. Doctors in training complete the diploma on a part-time basis over the first two years of training.
35. The knowledge needed to practise AVM is not covered at any other point in medical training and the depth of comprehension needed requires a taught degree. The course involves taught components or lectures, individual study and tutorials; learning is assessed through prepared essays, presentations and unseen written examinations.
36. The Diploma is a theoretical course intended to provide knowledge that underpins and complements speciality training. It was designed to ensure that solid theoretical knowledge accompanies and enhances clinical training.
37. The diploma is awarded following successful completion of eight separate modules:
1. Audiovestibular Physics
 2. Anatomy and Physiology of the Audiovestibular System for Audiovestibular Physicians
 3. Clinical Diagnostics for Audiovestibular Medicine
 4. Clinical Sciences Allied to Audiovestibular Medicine
 5. Vestibular Medicine and Rehabilitation
 6. Adult Audiological Medicine and Rehabilitation
 7. Paediatric Audiological Medicine and Rehabilitation
 8. Research Methods and Statistics

38. The MSc in Audio vestibular medicine involves the same course as for the diploma with an additional research project and dissertation. Doctors in training have the option of completing the dissertation and obtaining the MSc if they wish, but this is not compulsory. The MSc acts as the theory which needs to be consolidated by clinical work.
39. Doctors in training reported that the teaching and courses involved in the Diploma and MSc were extremely useful and relevant to training. They reported that the qualifications cover a very broad base of information that is required for training.
40. The assessment system for the specialty also includes the following Workplace Based Assessments during training:
- Multi-Source Feedback (MSF)
 - mini-Clinical Evaluation Exercise (mini-CEX)
 - Case-Based Discussion
 - Direct Observation of Practical Skills
 - Patient Survey
 - Audit Assessment
 - Teaching Observation
 - Practical Procedures Sign-off

Concerns about the assessment system

41. The Diploma in Audio vestibular medicine is currently run by University College London (UCL) and is a mandatory part of the curriculum. However, UCL is considering discontinuation of the diploma.
42. The cost of taking these qualifications falls on the doctor in training. At the time of this review, it cost each doctor in training £10,500, on top of travel, to complete the Diploma in Audio vestibular medicine followed by the MSc course. The MSc is not compulsory but doctors in training tend to complete the course anyway to boost their employment opportunities upon completion of training.
43. As it is not possible for the Diploma and MSc courses to be provided through distance learning, the North West doctors in training are heavily disadvantaged and are required to travel to London as frequently as three days a week.
44. Doctors in training reported a lack of flexibility in taking the modules towards the MSc. Those doctors in training that were part-time could not afford to be taken away from clinical duties three days a week (paragraph 16).
45. The specialty is working on building a knowledge-based assessment into the curriculum so that it is no longer dependent on the volatility of an external body to deliver the assessment system.
46. The new knowledge-based assessment (KBA), with some extra courses to be added to the curriculum, would replace four of the taught modules, namely the Clinical Sciences Allied to Audio vestibular medicine, Vestibular Medicine and Rehabilitation, Adult Audiological Medicine and Rehabilitation and Paediatric Audiological Medicine

and Rehabilitation. A Certificate (in the four remaining basic science modules: Audio vestibular Physics, Anatomy and Physiology of the Audio vestibular System, Clinical Diagnostics, and Research Methods and Statistics) would replace the Diploma, which covered eight modules. The modules chosen for the certificate are at less of a risk of being discontinued since they are core modules for any MSc course in Audiology.

47. The specialty was also reviewing requirements to undertake the MSc. There was a possibility of removing the MSc altogether and potentially replacing the course in the curriculum with an exit examination.
48. The experience of doctors in training of workplace based assessments was that some of them have become too formal (summative rather than formative), that they could be shortened in length and be less of an administrative burden. There could be more flexibility around the assessments and they could be tailored better to the nature of the different areas of practice being assessed.
49. There was no benchmarking in place to support clinical and educational supervisors completing workplace based assessments. Doctors in training tended to have a variety of clinical and educational supervisors during training and this could lead to inconsistency in completing the forms.
50. Multisource Feedback (MSF) was difficult to obtain in such a small specialty. The requirement of the curriculum to undertake one MSF exercise every year and to obtain feedback from 12 people was proving difficult. In comparison to another small specialty: Immunology requires MSF on a bi-annual basis, which can be collated over the two year period. A move to one MSF exercise per two years would be more practical in AVM training.
51. Consultants and trainers referred to a gap in assessments to test non-clinical skills such as leadership and management. Mini-CEX was used to feedback to doctors in training on these skills. Training in the specialty had no structured assessments in this area yet leadership and management feature heavily in the role of a consultant.
52. Patient feedback forms were due to be introduced in to the specialty to raise awareness amongst consultants and doctors in training of what patients expected from them. The forms could be added to the curriculum so that feedback from patients features in training. A patient survey is already part of the assessment framework under the JRCPTB, a generic form and guidance is available on the website.

Quality and availability of teaching

53. Doctors in training were satisfied with the quality of regional teaching and said that they were released for it and expected to attend. They said study leave was also supported but that it was mostly self-funded and could be expensive (paragraph 42). Feedback was sought on the regional training days and learning points taken to improve them.
54. Doctors in training said that although they were released for regional teaching and encouraged to go to other regions for relevant teaching, in practice it could be difficult to attend, particularly for those doctors in training in the North West who were required to travel to London frequently.

Support for trainers

55. Consultants are required to sign up to courses to become trainers. These are accredited courses, for example on providing feedback to doctors in training and creating an environment that encourages proactivity from doctors in training.
56. HENW funds a postgraduate certificate course at Edge Hill University aimed at ST5 doctors in training and trains them up to the level of a clinical supervisor. The modules map to clinical supervision, educational supervision and educational leadership. All doctors in hospital training are encouraged to attend and where there are spare places it is sometimes also open to consultant teachers. It is not open free of charge to doctors in training from other LETBs but they would not be denied a place if their LETB was willing to fund it.
57. Clinical and educational supervisors receive feedback specifically on their supervisory roles as part of their general appraisals. They reported that they felt well supported in their roles by colleagues, the Associate Dean and Medical Education Director.
58. Some of the clinical and educational supervisors had time allocated in their job plans for their supervisory roles but some had not. The time should be negotiated in their annual appraisals.
59. Preparation for the GMC's scheme on the [recognition and approval of trainers](#) was reported to be on track for the specialty.

Acknowledgement

We would like to thank the Specialty Advisory Committee, the JRCPTB, the Lead Dean, and all the people we met during the visits for their cooperation and willingness to share their learning and experiences

Appendix 1: Visit Details

Visit team

Team leader	Rosie Luszkat
Visitor	Jill Edwards
Visitor	Richard Antrobus
Visitor	Sally Williams
GMC staff	Emily Saldanha, Jessica Lichtenstein
Visit Dates	<p>9 July 2014: meeting with Specialty Advisory Committee (SAC)</p> <p>24 July 2014: meeting with Lead Dean and JRCPTB Chair</p> <p>19 September 2014: meeting with doctors in training at a training day and meeting with academic lead</p> <p>17 October 2014: meeting with trainers and consultants at a training day</p> <p>5 November 2014: meeting with Dean for HENW</p> <p>17 December 2014: meeting with AVM Associate Dean, training programme director and doctors in training at HENW</p>

Appendix 2: HENW Review of the Audio Vestibular Training Programme



North Western Deanery

POSTGRADUATE EDUCATION QUALITY MANAGEMENT

Audiovestibular Medicine Training Programme Review

Background

As part of the Deanery's quality management processes, small specialties that are not routinely reviewed by the scheduled postgraduate education monitoring visits to Trusts can be subject to a programme review. The Deanery is conducting a series of such reviews of the smaller specialties within the School of Medicine. Audiovestibular medicine is the second such speciality to be reviewed in 2012. In addition, the SAC had raised concerns with the GMC after the unexpected loss of a major training site. Therefore, the review of this programme was prioritised within the schedule of reviews. The review took place on Thursday 29th November 2012 and was conducted by the following team:

Name	Title
Mr J Adams	Director of Postgraduate Hospital Training
Dr A Jones	Associate Dean
Dr R Coward	Head of the School of Medicine
Ms B Miller	Assistant Quality Manager
Ms A Davies	Specialty School Manager
Dr E Raglan	Audiovestibular Medicine Consultant, London (External)
Dr T Tham	Head of the School of Medicine (Northern Ireland Medical & Dental Training Agency)

The team reviewed a range of background information including trainee outcome information, Deanery STC minutes, GMC survey results, and the CfWI Workforce summary and recommendations for the specialty. The background information appeared to indicate that the programme is well organised and enabling the trainees to achieve and progress. The aim of the review is to support the Training Programme Director (TPD) in further improving the programme.

All trainees currently on the programme were invited to the review. Each consultant STC representative was invited to attend and asked to invite another consultant from their department. The discussions were based around a set of focused questions, covering aspects of the programme and so not all the GMC domains were covered. The review commenced with a presentation by the TPD, followed by focused discussions with the trainees and then the consultants. The review panel then met with the TPD to discuss key issues and recommendations.

Findings

Presentation by Training Programme Director

Dr Veronica Kennedy gave a comprehensive presentation that commenced with an overview of the North Western, Trent and Wales (NWTW) programme, including details on each site that delivers training.

- The requirements for CCT were clarified which include experience in both paediatric and adult placements, together with the schedule each trainee should follow.
- Trainee numbers were outlined: currently, the programme has one full-time and one part-time (0.6) trainee; one from an ENT background undertaking CMT training and one paediatric trainee developing an interest in AVM (0.4). There are 2 vacant posts.
- The aim of the training programme is to deliver the curriculum across the North West, Trent & Wales area flexibly, to meet trainee-led learning objectives. The rotations are responsive to the needs of the trainee. The curriculum has been mapped across the sites allowing trainees to reach Level 3 competencies, although there are some areas where there are low numbers of cases and where further experience needs to be gained (Dizziness in Children; Practical Procedures in Adult Vestibular Medicine; Adult Psychology), some of which can be covered by attending specialist clinics in London when doing the diploma. The training sites are:
 - Bolton
 - Bury/Rochdale
 - Cardiff
 - Derby/Nottingham
 - Manchester
 - Preston
- When the adult service at CMFT was discontinued, links with Wales and Derby/Nottingham were developed in order to strengthen the learning opportunities in adult services, in addition to those offered at Bolton.
- Examples of rotations across the different sites were given, illustrating the flexibility of the programme whilst still meeting the curriculum requirements.
- The academic knowledge required was described. The diploma in audiovestibular medicine forms the knowledge based tuition and assessment for this specialty and is essential for the award of the CCT. This is usually completed on a part-time basis over the first two years of training. Both the diploma and the additional modules for the M.Sc. are provided by University College London. The challenges of the travel commitments and costs were highlighted.
- The programme outcomes were reported; in the past three years there have been 3 RITA G outcomes and ARCPs have been mainly outcome 1, although 2 had 2/3 outcomes and both resigned, one (with family problems) despite transferring to a vacancy in Cardiff.
- The STC structure was outlined: all six centres are represented together with neurology and paediatrics representatives.
- The strengths of the NWTW programme were outlined:
 - Small number of trainees allowing individual interests to be accommodated
 - Easy access to trainers, supervisors and mentors
 - 1-1 training/supervision
 - Wealth of specialised services including implants, specialised mental health for the deaf, neurosciences, cleft lip and palate, together with research opportunities, access to some audiovestibular diagnostics and clinical networks.
- Challenges to the programme include:

- Geographical distance
- Cost of diploma/M.Sc.
- Recruitment
 - National recruitment
 - CMT requirement a disincentive/barrier for ENT trainees
- Small specialty – concern re career opportunities
- Admin support/finance

These challenges are being addressed by early disclosure of the rotation sites to trainee applicants; ensuring curriculum objectives are met by adding 2 sites to the rotation (Derby/Nottingham and Bury), moves towards a modular diploma rather than the M.Sc., with research needs being met separately, and use of teleconferencing and videoconferencing for meetings.

- A survey of the supervisors was conducted in 2012 and all had met or were in the process of meeting GMC standards for trainers. There are regional training sessions for supervisors and future plans include considering how the educator role is included in the appraisal process and encouraging trainers to join AoME.

In summary, the TPD confirmed that informal trainee feedback and limited GMC trainee survey findings indicated that trainees were happy with the training programme. The success of the programme is highlighted by the fact that 2 trainees who have just completed the programme have gained consultant posts.

Audiovestibular medicine trainees

Four trainees attended, including 2 who had just completed the programme.

Job descriptions

There is a written description of the audiovestibular programme. The trainees felt that they were clear about the programme: they know where the posts are going to be, what the experience will be and how it maps to the curriculum. Given the geographical spread of the sites within the programme, some posts require trainees to travel considerable distances. They all confirmed they were clear about this when they applied to join the programme but emphasised that the recruitment information must continue to make this clear to future applicants. They also noted that the requirement for trainees to have completed 1 year of CMT training was a disincentive to trainees wishing to join the specialty from an ENT background.

Induction

All trainees confirmed that they received site specific inductions when they rotated to a new site and the majority were also able to attend Trust inductions where necessary. It was reported that not all the trainees who rotated to CMFT were provided with a Trust induction. Two trainees who joined the programme from a paediatrics background felt they were inducted well to the specialty.

Training experience

The trainees felt that there was enough experience and that the work load was satisfactory, enabling them to meet the needs of the curriculum. As there were only a small number of trainees, they said the programme was able to respond very flexibly to their individual training needs and interests. All learning opportunities were outpatient based and the programme provided well balanced experience across both paediatrics and adults. There was graded learning experience in all placements, with trainees being closely supervised initially. They described being able to observe the consultant, then undertake a case with the consultant observing, then discuss the case afterwards, enabling them to move towards more independent practice. They had the opportunity to see new cases as well as review cases. In the final year of training, they still discussed cases with the consultant, if not at the end of the clinic, then the next day, and there was also an opportunity to discuss via WPBAs.

One trainee had been to Nottingham/Derby and commented that the clinics and training were excellent, with outstanding supervision and teaching from the consultants. It was a very busy placement but interesting with a good range of patients at tertiary level. The only drawback was the distance. Bolton was judged to be very good with a range of useful learning opportunities. The trainees that had been to clinics at Preston also said the graded exposure was very helpful. Some trainees had experience of psychiatry clinics and also genetics clinics; again, these were described as useful experience. Some trainees had undertaken this experience as a secondment which they indicated had been easy to organise, as well as providing curriculum relevant learning opportunities.

One trainee reported on their experience of attending some of the specialist clinics in London. They indicated that it was better if they could be arranged to tie in with the diploma/M.Sc. course but this was not always possible. They said they had to obtain prospective approval for these to ensure that they are recognised and count towards their training. They worked out their aims and objectives which they discussed with the consultant responsible for the clinic and there was usually an opportunity to undertake WPBAs and receive feedback on their work. A formal placement report was also provided. It was reported that trainees had to arrange and pay for CRB clearance and also complete the occupational health forms required by the relevant Trust. However, a trainee who had just commenced this experience said much of the administration was organised for them by the relevant Trust.

All of the trainees confirmed that they were not exposed to responsibilities beyond their experience or competence nor were they expected to participate repeatedly in tasks with little educational value. They worked well with the audiologists, even though there was some minor overlapping of work.

They indicated that as their posts were supernumerary, service pressures did not impact negatively on their training. However, there had been an issue when the adult service had been discontinued at CMFT. Trainees in post at the time had to be placed at Bolton at short notice and felt that they were not well supported by the Deanery. They said they should have been given much longer notice to enable better planning, particularly for trainees with family commitments.

Support and supervision

All trainees confirmed that they always had ready access to senior support at all sites and that they received constructive feedback from their supervisors. They all confirmed they felt they were progressing and developing their practice as a consequence of the feedback they received. Trainees who had been to Derby/Nottingham reported that they sometimes had the opportunity to discuss patients before they saw them, which was particularly supportive.

The trainees gave examples of how they were coached in learning new procedures and techniques e.g. in paediatric audio there was the opportunity for very hands-on clinical skills and in the London clinics there was more specialist work and the opportunity to learn specific skills and procedures. They said this informed their clinical practice as they were then aware of the types of specialist investigations that could be arranged for patients if required.

Clinical governance

The trainees confirmed that they all had an opportunity to undertake audit, implement audit findings and lead quality improvement.

It was reported that the Trust induction programmes at each site included training about the critical incident reporting system in place. However, none of the trainees had experience of having to report an incident.

Assessment

The trainees confirmed that they receive appropriate teaching in the clinical environment from the consultants and also from the radiologists, physiotherapists and audiologists. All confirmed that they were able to complete the required WPBAs as specified in the curriculum.

Educational supervision

All the trainees confirmed that they have a named educational supervisor who oversees their training throughout the programme, even when they attend sites outside the region. One trainee described how well this had worked when they undertook the placement at Derby/Nottingham. The clinical supervisors use the e-portfolio so that the educational supervisor is able to maintain an overview of progress and is aware of any issues. Formal meetings are held 3 times in each placement. The trainees commented that they found their supervisors supportive and well trained for their role. They confirmed that they received appropriate feedback from their educational supervisors. All the trainees received careers support and as it is a small speciality, all the consultants provided help and advice. The trainees said they felt the programme prepared them well for transition to the next step in their careers: 2 of the trainees had just become consultants and one commented that they were well prepared and that it “gave me what I needed”.

All trainees were happy with the annual review process: one commented that they knew what they needed to do and there were no surprises. The ARCP process worked well and adhered to Gold Guide standards. Another trainee commented that they found the RITA process helpful, as they were able to stop, review and plan for the following year.

Formal teaching

The trainees reported that formal teaching was delivered via the diploma/M.Sc. course in London. Whilst the curriculum requires the achievement of a diploma, most trainees carried on to complete the M.Sc. They said they needed the M.Sc. to remain competitive in the jobs market. They said the course was partly funded by the Deanery and they could apply for a student railcard. However, they still incurred significant costs. They described the diploma/M.Sc. as hard work and said that it involved going to London for 30 days each year. Although they got used to the travelling required, it involved long days and required a great deal of personal commitment. However, they were clear about the requirement to undertake the training when they applied to join the programme.

The trainees said the course was very good, as it was run by audiovestibular physicians and met the requirements of the curriculum with essays, presentations and exams for each module. There were 12 trainees on the course and the format is usually lecture based, but they do stop to ask the trainees questions. The trainees were working on suggestions to improve the way the diploma/M.Sc. is delivered. Some of it could be delivered by distance learning and audio-visual conferencing, making better use of new technology. Some trainees said they tried to arrange some of the specialist London clinics to coincide with the course, to reduce the travelling and costs. The trainees noted that the diploma/M.Sc. offered the opportunity to undertake research, as well as publications and poster presentations.

The diploma/M.Sc. does not offer the opportunity to learn additional skills such as consent, audit, presentation skills and communication skills. These skills are not formally taught, and the trainees felt they ‘learnt by doing’ as well as observing the consultants. Two trainees who had just completed the programme said they had the opportunity to undertake the Deanery’s Medical Leadership in Practice course. They said it was very good and useful and one described how they had applied the principles to initiate change in their final placement. Another trainee was also undertaking the Deanery Edge Hill course but commented that it was difficult to do this at the same time as the diploma/M.Sc.

The trainees said they were also able to access other relevant learning opportunities such as neurology and paediatrics. They said that most of these were within the region but they been able to access a training day held in London via videoconferencing. Other learning opportunities were also available such as BAAP conferences, at which they had the opportunity to present.

Working relationships

All the trainees confirmed that working relationships were good at all sites and they felt like valued members of the teams they worked with, even though the posts are supernumerary. They worked with a range of

other professionals, such as audiologists, and the teams worked well. There were no reports of inappropriate behaviour. The trainees also reported that they worked well with each other, with 2 outlining how they met up when they attended the diploma/M.Sc. course in London. This also enabled them to meet with colleagues on the London programme. The trainees were clear that they could approach the TPD if they or a colleague were experiencing any difficulties, there were mentors on offer and they were also told who they could contact outside the specialty if necessary.

The trainees were aware of the lead employer and one trainee commented that when they joined the programme they had been helpful in sorting out an issue for them. The trainees knew who to contact in the education department at the Deanery regarding annual leave and study leave and were aware of who the SSM was.

Study leave

All the trainees confirmed that they were able to access appropriate study leave.

Summary

All trainees said that they would recommend the audiovestibular training programme in the North Western Deanery. They highlighted the level of hands-on practical exposure, the interaction with supervisors and the opportunity to discuss cases as the highlights. They commented that all the supervisors knew them and their needs and were able to guide them well. The trainees who had just completed the programme commented that it prepared them well to take on their new roles as consultants. One had just obtained a substantive post as consultant and another, a locum post.

The trainees could not identify any major concerns with their training but said the programme could be further improved if it was more self-sufficient so they did not have to travel to London as frequently. They said that whilst some of the specialist clinics in London were interesting, they felt they were just ticking a box for the curriculum requirements. Some specialist clinics could be accessed in Sheffield and it would be helpful to explore this possibility. One trainee commented that their PYA targets had required attendance at London clinics, even though similar experience could be gained within the region. The diploma/M.Sc. course needed to make better use of new technology so that the face-to-face sessions could be reduced.

Audiovestibular medicine consultants

5 consultants attended from Bury/Rochdale, CMFT (Community), Preston, Bolton and Derby/Nottingham. Written input was provided from Wales.

The consultants were a mix of clinical and educational supervisors and were selected or appointed in a variety of ways. The majority confirmed they had undertaken relevant training to enable them to comply with the GMC standards for trainers. Some reported they had also undertaken additional training such as the Deanery Edge Hill course or the London Deanery training. Most consultants had job plans that reflected the Deanery guidelines on educational roles and SPA time, but some did not and felt there was a need to clarify the requirements. The consultants from CMFT and Pennine stated that they have an annual appraisal that reflects their role as an educator and at Derby it is included if raised by the educator, but is not incorporated in the standard appraisal system. However, it was reported that appraisals in Bolton did not yet include educational roles.

The consultants outlined how they delivered individually tailored learning opportunities matched to the curriculum. They supported the trainees in selecting which clinics to attend depending on their learning needs. They described assessing trainees examining patients, checking their letters and discussing cases with them. They also said they made time in all their clinics so trainees could observe them interacting with patients. In order to ensure that trainees had experience in different areas the consultants directed them to other professionals such as audio-physiotherapists. If a consultant was off work they made their colleagues aware and planned specific work for the trainees, perhaps planning a secondment if on leave for a while. The consultants confirmed they were very supportive of the assessment process and made time to

undertake WPBAs. They also appraised each trainee annually using the NHS appraisal documentation. Most of the consultants felt that service pressures did not impact negatively on training, as the trainees were supernumerary. However, the consultants sometimes ended up staying late to catch up on work, because of their training activity. Trainees' attendance at formal teaching is considered essential and the consultants worked around the teaching dates in the calendar. They actively encouraged the trainees to attend as they considered the training very valuable

The supervisors liaised with trainers from other Trusts at STC level to ensure that trainees' placements and secondments fit together to meet the curriculum requirements for each individual. They highlighted the good communication that exists between the trainers at all the sites. The consultants said their initial perception was that there was insufficient breadth of adult experience in the North West as it was mainly adult rehabilitation; this was partly because the adult service had been discontinued at CMFT, patients were not referred and also because Bolton has not been allowed to expand. There were limited services elsewhere, with patients being referred to ENT for some services. However, over the last 18 months, much work has gone into developing links with other areas such as Wales and Derby/Nottingham. There are now 8 adult clinics per week in Bolton and Derby/Nottingham for 1.5 trainees, which the consultants agreed offered sufficient opportunities for trainees without needing to send them to London. They acknowledged that trainees' attendance at the London clinics was also an additional burden on their London colleagues. They identified a number of additional clinics that could be utilised within the NWTW rotation including rehabilitation clinics run by audiologists in Nottingham and ataxia clinics in Sheffield. Both these opportunities needed further exploration.

The consultants confirmed they were aware of the mechanisms to support trainees in difficulty and gave an example from CMFT where they discussed support strategies with the TPD and the Postgraduate Dean to produce a positive outcome.

The consultants discussed the lack of detailed information from the GMC trainee survey due to the small numbers of trainees. They indicated they would like more feedback from the trainees about the programme and their performance as trainers. Some sites do conduct exit interviews with trainees but it was suggested that the STC could look at ways of collecting more structured feedback from all trainees on the programme.

The consultants commented on the difficulty of running training days because of the small numbers of trainees. They outlined how they tried to address this by organising and inviting the trainees to meetings on specific issues and gave an example of a recent event, 'mental health in deaf children'.

The consultants acknowledged the issues around the diploma/M.Sc. programme, including the costs and travel commitments. They confirmed the trainees' view that this information is explicitly raised with trainees who apply for the programme so they are aware of the commitment required. It was suggested that changes to the delivery method and better utilisation of new technology needed to be considered. They pointed out that there are small numbers applying to the specialty and this needed to be addressed if the CfWI workforce projections are to be met. The entry requirements that stipulate ENT trainees with FRCS require 1 year of CMT training deters such trainees from entering the specialty. They suggested ways in which the specialty could be promoted including developing taster sessions for foundation trainees and more opportunities for medical students to experience the specialty. A 1 year M.Sc. programme in audiovestibular medicine for those working in ENT has recently been agreed and the impact on the specialty could be negative.

Summary

The consultants felt that there were a number of strengths of the audiovestibular medicine programme in the North Western Deanery. They said that they enjoy their work and all the trainers were enthusiastic and network together well. There is good dialogue between Derby/Nottingham and Manchester supervisors. The programme is new, flexible and evolving. Patient satisfaction is high and the service provision is good. They also highlighted the importance of the programme in delivering the future consultant workforce for the

North of England. As most trainees tend to stay and work in the area they have trained in, and the only other training programme is London-based, the NWTW programme is vital to ensure patients can access local services.

The consultants reflected on a few areas that could be improved including changes to the delivery of the diploma/M.Sc. programme to reduce the travelling time. The profile of the specialty needed to be raised, particularly with medical students and foundation trainees. There is a need to influence the Specialty Advisory Committee (SAC) to amend the entry requirements regarding entrants from ENT. Trainee feedback was another area that needed more work.

Review team summary and recommendations

The review team considered the discussions with trainees, consultants and the TPD, as well as the background information. The team wished to commend the TPD and STC for organising and delivering a successful programme. All the trainees are being supported to develop and achieve and all would recommend the programme to others. The TPD clearly has a good overview of the programme including the learning opportunities that are available across a wide geographical area. The flexible, bespoke nature of the programme that meets individual training needs and enables trainees to meet all curriculum requirements is particularly commended, as is the enthusiasm of the trainers and their commitment to developing and supporting the learners. The trainees felt well supported and the travelling is accepted as it is clearly spelled out at the beginning of the programme. The programme clearly prepared trainees for their first consultant posts and provides trained specialists for an under-resourced area. The team also agreed that there is sufficient adult experience within the programme to meet the requirements of the curriculum.

Recommendations to the STC

1. The TPD should work with colleagues in London to explore the opportunities to better exploit new technology to deliver the diploma/M.Sc.
2. The TPD should work with colleagues across the region to explore additional learning opportunities, particularly in relation to adult services.
3. The STC should review the aspects of the curriculum that have to be delivered in London and make sure they are well planned and structured to mesh with attendance for the diploma/M.Sc.
4. The STC should explore opportunities to raise the profile of the specialty, e.g. introducing taster days or sessions for medical students, foundation and core medical trainees.
5. The STC should write to the SAC regarding the entry requirements from ENT, which are impacting negatively on recruitment.
6. The TPD and STC should ensure that clinical and educational supervisors are aware of the requirements to meet the GMC standards for trainers and the Deanery guidance on job planning.
7. The TPD and STC should explore the possibility of making the Deanery Edge Hill course available in ST5 rather than ST3, to avoid clashing with the diploma/M.Sc. course.
8. The STC should consider introducing end of placement questionnaires to improve feedback from trainees.