

Visit report on Belfast Health and Social Care Trust

This visit is part of the Northern Ireland national review.

Our visits check that organisations are complying with the standards and requirements as set out in [Promoting Excellence: Standards for medical education and training](#).

Summary

Education provider	Belfast Health and Social Care Trust
Sites visited	Royal Victoria Hospital (RVH)
Programmes	<ul style="list-style-type: none"> ■ Undergraduate ■ Foundation ■ Core medical training (CMT) ■ Core surgical training (CST) ■ General (internal) medicine (GIM) ■ General surgery ■ Obstetrics and gynaecology (O&G) ■ Trauma and orthopaedics (T&O)
Date of visit	1 March 2017
Overview	<p>The Belfast Health and Social Care Trust (hereafter referred to as the trust) is the biggest trust in Northern Ireland which has eight hospitals delivering care to those who live in Belfast and providing specialist services to all of Northern Ireland.</p> <p>During our visit to the trust we met with medical students from Years 3, 4 and 5 of Queen's University Belfast School of Medicine, Dentistry and Biomedical Sciences (QUB), doctors in training, clinical and educational supervisors, and the trust's education management team. Whilst we visited the Royal Victoria Hospital, we met with those with</p>

experience across the trust rather than just the RVH site.

We identified a number of areas working well in the trust. The commitment to education in the trauma and orthopaedics department stands out, and we were also pleased to hear clinical supervision appears to be working well within the trust despite the service pressures and gaps in rotas. However, the rota gaps are having an impact on some departments and the pressures this then puts on the doctors in training to fill gaps.

Areas that are working well

We note areas that are working well where we have found that not only our standards are met, but they are well embedded in the organisation.

Number	Theme	Areas that are working well
1	Theme 1: Learning environment and culture (R1.3)	In trauma and orthopaedics and general surgery we found that, when serious untoward incidents happen, lessons learnt are being shared with doctors in training.
2	Theme 1: Learning environment and culture; Theme 2: Educational governance and leadership (R1.7)	Clinical supervision is working well despite the service pressures.
3	Theme 1: Learning environment and culture (R1.15)	There was evidence of strong educational leadership in general surgery. Training needs are being assessed and educational opportunities are being allocated flexibly and appropriately.
4	Theme 2: Educational governance and leadership (R2.1)	We found an effective educational governance system operating at different levels within the trust along with clear links to the trust board.
5	Theme 3: Supporting learners (R3.2)	Following serious untoward incidents in obstetrics and gynaecology there was support from midwives and specialist psychologists for doctors in training, in addition to supervisor support.

6	Theme 1: Learning environment and culture; Theme 3; Supporting learners (R5.9)	We heard in trauma and orthopaedics that consultants role-modelled excellence in medical education and that this is then emulated by doctors in training.
7	Theme 5: Developing and implementing curricula and assessments (R5.9)	Clinical exposure is good. Doctors in training are obtaining sufficient practical experience to achieve the clinical competencies required by their curricula.

Requirements

We set requirements where we have found that our standards are not being met. Each requirement is targeted, and outlines which part of the standard is not being met, mapped to evidence we gathered during the course of the visit. We will monitor each organisation's response to requirements and will expect evidence that progress is being made.

Number	Theme	Requirements
1	Theme 1: Learning environment and culture (R1.12)	Issues with the rotas for higher surgical doctors in training at the trust must be resolved. Rotas are not European Working Time Directive (EWTD) compliant and could have adverse effects for doctors in training.
2	Theme 1: Learning environment and culture (R1.12) Theme 3: Supporting learners (R3.2)	The organisation and distribution of the rota for junior doctors in training must be reviewed by the trust. The design of the rotas must also be reviewed in order to minimise the adverse effects of fatigue and workload, and undue pressure felt by the doctors in training to attend their shift when unwell.
3	Theme 3: Supporting learners (R3.1)	Learning outcomes from equality and diversity training must be clearly understood and applied in practice, such that learners are able to demonstrate they meet the professional standards required of them. Equality and diversity training must be appropriately monitored, and learners and educators must be up-to-date with their training.

Recommendations

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

Number	Theme	Recommendations
1	Theme 1: Learning environment and culture (R1.13)	Induction at the trust, both trust and departmental, should be reviewed to ensure a consistent and positive experience for different levels of doctors in training and across departments.
2	Theme 1: Learning environment and culture (R1.14)	The trust should review evening handover in general surgery. The evening handover is not consultant led, takes place at variable times with differing individuals and does not provide a good learning opportunity.
3	Theme 1: Learning environment and culture (R1.16)	The trust should ensure doctors in training have protected time for learning and are able to meet their curriculum requirements, despite service pressures.

Findings

The findings below reflect evidence gathered in advance of and during our visit, mapped to our standards. Please note that not every requirement within *Promoting Excellence* is addressed; we report on 'exceptions' eg where things are working particularly well or where there is a risk that standards may not be met.

Theme 1: Learning environment and culture

Standards

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.*

Raising concerns (R1.1); Dealing with concerns (R1.2); Learning from mistakes (R1.3)

- 1** Incident reporting in the trust was unclear to us. Medical students, foundation doctors and doctors in training we met all said they would raise concerns with someone more senior in the first instance and some said they would raise more serious concerns through the trust's online system for reporting concerns (Datix) or through an IR1 (incident reporting) form. Some doctors in training said they would be guided by a consultant on when to raise a concern in Datix, which suggested an inconsistency between individuals and departments.
- 2** Of the foundation doctors and doctors in training we met, very few of those who had completed a Datix said they had received direct feedback as a result of this.
- 3** Doctors in training in obstetrics and gynaecology (O&G) said they are encouraged to raise concerns through IR1 and Datix and that these are used for learning in the department. Doctors in training in trauma and orthopaedics (T&O) spoke of formalised mortality and morbidity meetings and said they make sure they are recording incidents in the department's mortality and morbidity book so it is discussed at that forum. Doctors in training in general surgery said they feel there is a culture of learning from mistakes in the trust.

Area working well 1: In trauma and orthopaedics and general surgery we found that, when serious untoward incidents happen, lessons learnt are being shared with doctors in training.

Supporting duty of candour (R1.4)

- 4 Whilst there is no statutory duty of candour in Northern Ireland, medical students were all aware of their responsibilities to be open and honest with patients. Doctors in training in general surgery said the Royal College of Surgeons are clear of the need to identify concerns or harm and the need to communicate this to patients.

Appropriate capacity for clinical supervision (R1.7)

- 5 The education management team feel that although workload can be high, clinical supervision is always good. Doctors in training we met across specialties confirmed this, and said clinical supervision is good during the day and out of hours, and they could always access consultant support via telephone if necessary. Doctors in training in O&G said there are certain procedures within their curriculum for which consultant supervision is required, and they have had no problems getting this support.

Area working well 2: Clinical supervision is working well despite the service pressures.

Appropriate level of clinical supervision (R1.8)

- 6 Medical students said consultants supervising them mostly seem to be aware of QUB's curriculum but that it is variable. They highlighted O&G and general surgery as good examples, noting they adapted learning to the students' year of medical school.

Appropriate responsibilities for patient care (R1.9)

- 7 We heard from medical students that they are never asked to do anything outside of their competence. Doctors in training said they never feel as though they are working outside their competence and are able to access support if they are in this situation.
- 8 Doctors in core training in general (internal) medicine (GIM) felt they were sometimes pressured by senior members of staff within the trust to discharge a patient before they felt it appropriate to do so. This resulted in an increased anxiety amongst these doctors in training.

Identifying learners at different stages (R1.10)

- 9 We saw throughout the visit that all doctors had different lanyards which made clear the levels of doctors in training to patients and staff.
- 10 Foundation Year 2 (F2) doctors and doctors in core training are all on the same rota, with the same clinics and same responsibilities, and foundation doctors said they feel as though there is no differentiation to their roles. Doctors in core training in surgery said the lanyards helped to make clear the different levels of training and rotas named the F2 doctors and doctors in core training clearly. Doctors in core training in GIM said they didn't feel as though the experience they are getting is any different to

the F2 doctors, but that this hadn't impacted on their learning outcomes and workplace based assessments.

- 11** The education management team said the F2 doctors were told only to work within their competence and that they were unaware of any issues amongst those working on the rota covering the different levels. Supervisors in general internal medicine said they are clear on the different curricula for F2s and doctors in core training despite the different levels being on the same rota. Generally, learners at different stages are clearly identified and given support commensurate to their experience.

Taking consent appropriately (R1.11)

- 12** None of the doctors in training we met with felt they were taking consent for procedures they shouldn't be and they were never under pressure to take consent for something they didn't feel comfortable with.

Rota design (R1.12)

- 13** Doctors in higher training in general surgery said they received increased on-call and elective experience at this trust which they described as a positive for curriculum competency and experience. However, it does mean their rota is not EWTD compliant which can cause fatigue. The education management team are aware of this and have been exploring options to resolve this with the Northern Ireland Medical and Dental Training Agency (NIMDTA).

Requirement 1: Issues with the rotas for higher surgical doctors in training at the trust must be resolved. Rotas are not European Working Time Directive (EWTD) compliant and could have adverse effects for doctors in training.

- 14** Doctors in higher training in T&O said their rotas are designed well, giving them the required experience.
- 15** Foundation doctors said they sometimes did not receive their rota until the day it was due to commence and so did not know where they were meant to be. We heard that they had contacted HR about this without resolution. The foundation doctors in general internal medicine said they had to decide amongst themselves who would be staying late as the rota hadn't been published, in effect organising their own cover at short notice. They also said that they sometimes feel pressured into covering night shifts. Some rotas are seven nights on with one day off before returning to days and under these circumstances foundation doctors said they use annual leave to reduce the effects of fatigue. Whilst the foundation doctors did not feel as though patient safety is compromised, they do feel it impacts on their ability to think clearly and to learn effectively.

Requirement 2: The organisation and distribution of the rota for junior doctors in training must be reviewed by the trust. The design of the rotas must also be reviewed in

order to minimise the adverse effects of fatigue and workload, and undue pressure felt by the doctors in training to attend their shift when unwell.

- 16** Doctors in core surgical training are on the same rota as foundation doctors, and also commented on the delay in receiving their rotas and the impact this had on them.
- 17** The education management team said they are aware that rota gaps are an issue, and that foundation doctors would like a 12 month rota but they currently issue a rota covering four months as this is easier for the trust to ensure that gaps are covered. They are aware this causes issues for the foundation doctors with planning holiday cover and life events over the next 12 months, as well as the timeliness of rotas which they know can sometimes be quite last minute. We heard that the education management team would like more involvement from senior doctors in the organisation of rotas instead of just leaving this with HR, and hope this means they can provide foundation doctors with a 12 month rota.
- 18** Doctors in higher training in GIM said they had noticed an improvement in their rotas as there are now more doctors on the wards and it has taken the pressure off them. They said this is as a result of changes made to their rotas in August 2016.
- 19** Doctors in training in O&G said staff shortages in their department can impact on their educational experience as they are providing required service. We heard this has also impacted on their ability to access study leave.

Induction (R1.13)

- 20** Doctors in higher training in general surgery and T&O said their induction to the trust is good, and although there were previously issues obtaining badges and car parking spaces, this is no longer a problem.
- 21** Doctors in core medical training said they had attended an evening designed to support those starting work on late shifts, where they were able to collect ID badges. Others who couldn't make this evening induction said they had to wait some time before receiving passwords and badges, which meant they were unable to receive emails or access wards. We heard from the education management team that this evening is available to all doctors in training.
- 22** We heard of a training tracker that had been implemented and funded by the education departments in five trusts, and is co-ordinated by the Belfast Health and Social Care Trust. The doctors in training said they found this helpful as it means they don't have to complete an induction at every trust. They said if the tracker is not up to date they are not able to access study leave, and they receive a reminder if their information is about to lapse.
- 23** Foundation doctors did not have a positive experience of trust induction, and said F2 doctors often can't get to the trust induction as they are in their foundation year 1

roles. We heard that a formal departmental induction wasn't received until a week after starting on ward duties and so the foundation doctors were required to facilitate their own induction by asking ward staff in an informal and unstructured fashion.

- 24** Doctors in core surgical training said they had a good departmental induction to T&O where they became aware of what is expected of them and felt this prepared them well enough to undertake their role in the department.
- 25** It appears that the trust induction is received differently by those at different levels of training, depending on their requirements of trust induction and their ability to attend. Experience of departmental induction was also variable.

Recommendation 1: Induction at the trust, both trust and departmental, should be reviewed to ensure a consistent and positive experience for different levels of doctors in training and across departments.

Handover (R1.14)

- 26** Doctors in higher training in surgery felt that the evening handover could be a bit disorganised due to colleagues being in surgical theatre. It is not used as an educational opportunity. This contrasts with their experience of the morning handover which they find to be much better. Doctors in core and higher training all said this is used as a good educational opportunity. Whilst the NTS results for 2016 show improvement from results in previous years, further improvement could be made in order to receive the most educational value from handover.

Recommendation 2: The trust should review evening handover in general surgery. The evening handover is not consultant led, takes place at variable times with differing individuals and does not provide a good learning opportunity.

- 27** We heard from doctors in training in trauma and orthopaedics that handover meetings are used as an educational opportunity to review radiological investigations and plans for future care.
- 28** Doctors in foundation training in general internal medicine spoke positively of the morning handover in acute medicine which all consultants attended. We heard evening handover also works well. In the 2016 NTS results, handover at sites in the trust received green outliers.
- 29** Doctors in training in O&G said they have a formal multidisciplinary handover every morning as well as a smaller night handover and an informal handover at 5pm. They said there are plans for the 5pm handover to become formalised. They found the handovers to be comprehensive and a good multidisciplinary learning opportunity. We heard that when the consultants in O&G are not present they will receive an electronic copy of the handover.

Educational value (R1.15)

30 Doctors in higher training in general surgery said they get good exposure to emergency surgical experience. Whilst we heard the workload can be intense, the doctors in training found the experience beneficial for training purposes.

Area working well 3: There was evidence of strong educational leadership in general surgery. Training needs are being assessed and educational opportunities are being allocated flexibly and appropriately.

31 Doctors in core medical training said they had received emails stating those who had completed their foundation training could bypass core medical training and become locums on the same rota. The doctors in training feel the locums then have priority over leave and certain procedures as they are filling the rota.

32 The education management team were aware of the doctors in training concerns around locums on the same rota and found it a challenge; they feel the locum posts need to be attractive in order to fill rota gaps.

Protected time for learning (R1.16)

33 The education management team said that doctors in training can't always get to training due to a heavy workload, particularly in general surgery and general internal medicine. They said the trust has been running Royal College of Physicians (RCP) training sessions at night to help this. However, we did not hear from doctors in training about the night training sessions and whether they are getting to these.

34 We heard from medical students that about 30% of their teaching is cancelled due to workload, but when the teaching does take place the students found it to be good.

35 Doctors in training in O&G said they are often not able to attend clinics due to service pressure and so will come in on their days off to attend clinics in order to meet their curriculum requirements.

36 Doctors in higher training in general surgery said their teaching programme has been somewhat fragmented as it was some time before they were able to attend to any teaching, and have not attended many in total. They said teaching is during the day when they are unable to get away from their duties, and so attendance is poor.

37 Foundation doctors said they were able to get to their generic skills teaching, and doctors in training in T&O also said they have protected time for teaching.

38 Doctors in core medical training said that if no locums were employed when they needed to attend teaching, then not all of the doctors in core training could attend. Therefore they would decide between them who attended and who stayed for service. Doctors in core surgical training also had the same issue and said where they all wanted to attend teaching, those at CT2 level give the opportunity to those at CT1

level. They were concerned they may not meet the mandatory requirement of teaching sessions.

- 39** Doctors in higher training in GIM said they were mostly able to attend teaching sessions unless they were working nights.
- 40** The education management team informed us it had been made clear to doctors in training that attendance at NIMDTA regional teaching is mandatory and they are not expected to remain on site and have no responsibility for clinical care during these sessions. It appeared to us that whilst the education management team were clear on what should happen and felt this message had been conveyed to doctors in training, those doctors in training we met felt unable to leave their ward duties.

Recommendation 3: The trust should ensure doctors in training have protected time for learning and are able to meet their curriculum requirements, despite service pressures.

Multiprofessional teamwork and learning (R1.17)

- 41** Medical students felt that multiprofessional teamwork worked well for emergency medicine placement and in O&G. They also spoke of simulation sessions where they had multiprofessional learning, and pharmacy based tutorials with the pharmacy students.
- 42** Doctors in core and higher training in general surgery were really pleased with the multiprofessional working opportunities they have, where they work with dieticians and physiotherapists. We also heard that a senior nurse attends handover and a sister will be on the ward round with them, which they find gives them a different perspective.
- 43** Doctors in training in O&G said they learn with and work closely with midwives, and feel that the maternity unit manages teaching well for all those training in the department.

Adequate time and resources for assessment (R1.18)

- 44** Most doctors in training we met with said they are able to get their workplace based assessments done, and although they may not always be of high quality they are able to get the numbers required. Doctors in core training sometimes found the feedback is better from a more senior doctor in training than a consultant.

Capacity, resources and facilities (R1.19)

- 45** Medical students found the resources in the trust good, we heard that they have access to computers, the library and good Wi-Fi coverage at the trust. They also said they are able to book the clinical skills lab, and whilst they stated that there is no direct support there they could access help from the wards.

- 46** Some of the foundation doctors we met with presented a less positive experience of the resources available to them at the trust and said there is no doctors' room with computers, and no learning room.

Accessible technology enhanced and simulation-based learning (R1.20)

- 47** We heard from the education management team that the trust has 10 simulation leads and their simulation work is recognised in their job plan. They felt some departments had moved forward quicker than others but are aware the doctors in training would like more access to simulation. We heard that NIMDTA has also developed a simulation post to coordinate simulation across Northern Ireland. The education management team stated that equipment is available to support simulation, but that further work is needed to develop a robust simulation faculty.
- 48** Medical students said they have more access to simulation from Year 4, and foundation doctors said access to simulation is variable across specialties with emergency medicine being highlighted as a positive.
- 49** Doctors in training in T&O said they are aware their department is trying to increase simulation learning which they would be able to use.
- 50** Doctors in higher training in general surgery said they have no access to simulation-based learning at the trust, whilst those in core surgical training said they received some ad-hoc teaching from consultants but nothing built in to their training programme.
- 51** Doctors in training in O&G and higher training in GIM had a more positive experience of simulation sessions and said they found it very useful and appropriate to their curriculum needs.

Access to educational supervision (R1.21)

- 52** Medical students said they have a named academic supervisor at QUB with whom they meet twice a year to review their e-portfolio.
- 53** All foundation doctors and doctors in training we met with said they had an educational supervisor whom they meet formally as well as seeing informally, finding them to be very proactive.

Theme 2: Education governance and leadership

Standards

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.*

Quality manage/control systems and processes (R2.1)

- 54** We heard from the education management team that at the trust board meeting they discuss outcomes of NIMDTA visits to the trust – where they will review the report and action plan, and discuss items that are in enhanced monitoring. Where there are particular concerns the trust would hold a risk summit which includes representation from NIMDTA, QUB, the Regulation and Quality Improvement Authority (RQIA), and the trust board. The education management team at the trust is very engaged with education at the trust board level.
- 55** We heard that the education management team manages items raised through NIMDTA visits by means of a database in order to log outcomes and track progress.
- 56** The education management team feel they can easily escalate significant issues to the Medical Director. A decision is made as to whether immediate action is required and which directorates should be involved. We heard this escalation is required rarely. Changes are due to take place to the trust management team in order to improve patient care, and the senior team think it will strengthen undergraduate and postgraduate links.
- 57** The education management team feels the relationship between the trust and NIMDTA has developed over the last few years. Trust representatives meet with NIMDTA colleagues every two months to run through a range of issues. The education management team feels that if there are any initiatives within the trust they work closely with NIMDTA to explore their merits.

Area working well 4: We found an effective educational governance system operating at different levels within the trust along with clear links to the trust board.

Accountability for quality (R2.2)

- 58** The education management team related how they report to NIMDTA on issues raised through NIMDTA visits along with other concerns/initiatives. They feel

collaboration across all trusts has evolved and NIMDTA works with all the directors of medical education across Northern Ireland.

Considering impact on learners of policies, systems, processes (R2.3)

- 59** Medical students said they provided feedback following their placements, and feel listened to by QUB. We heard they can report concerns through the year leads for the school's phase quality assurance committee (PQAC). Annually, the year leads talk through with students what has changed as a result of feedback. The students said they feel their feedback is listened to and actioned by QUB.
- 60** Doctors in higher training in general surgery said there has been a NIMDTA visit to the trust for the last two years. They all felt part of the process and provided feedback on their training to NIMDTA. They felt that changes had been made as a result of these visits.

Collecting, analysing and using data on quality, and equality and diversity (R2.5)

- 61** The education management team informed us that the trust holds equality and diversity data on all consultants, and the education department hold information on which trainers have attended equality and diversity training. NIMDTA holds data on doctors in training which isn't shared with the trust, meaning the trust is unable to analyse data on equality and diversity of its doctors in training.

Systems and processes to ensure a safe environment and culture (R2.11)

- 62** We heard from a number of groups we met with that cross-site transfer of patients in general internal medicine had been a concern. However doctors in training in general internal medicine feel that this has significantly improved with more senior doctors in training making the decision as opposed to a doctor in core training. They said the transfers of patients seem appropriate and they can track where patients are through a list. Supervisors in general internal medicine said lots of work has been done in order to improve the transfer of patients. There is a policy in place and the process is more robust.
- 63** Whilst doctors in training and supervisors felt the cross-site transfer of patients had improved, some foundation doctors noted pressure from senior staff at the trust to move patients. They found this could be an uncomfortable situation to be in. See [R3.3](#).

Sharing information of learners between organisations (R2.17)

- 64** The education management team said they receive information from NIMDTA in relation to doctors in training with health issues but the information can, on occasion be incomplete. The trust receives information from QUB regarding the medical students. We heard that information can also be shared informally. Where a doctor in

training runs into difficulty at the trust, the education management team said they will support them but also provide a link to NIMDTA for any additional support as required. The educational supervisor at the trust will be involved in creating an action plan for the doctor in training that will be shared with the new educational supervisor when the doctor in training moves to another trust.

Theme 3: Supporting learners

Standard

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

Good Medical Practice and ethical concerns (R3.1)

- 65** Medical students said they are made aware of good medical practice by QUB, including through the use of reflections in their e-portfolio. We heard they are encouraged to reflect on ethical problems and have ethics sessions within each specialty.
- 66** There was ambiguity amongst the medical students and doctors in training we spoke to, with the exception of those in trauma and orthopaedics, around what training they received on equality and diversity. Some doctors in training who had been part of the interviewing process for QUB medical students said equality and diversity was included in their training for this. Foundation doctors said there was a NIMDTA training day on equality and diversity during F2.
- 67** Supervising consultants we met said they were required to undertake equality and diversity training in order to be recognised as trainers. The education management team felt the focus had been more on trainers than those in training.

Requirement 3: Learning outcomes from equality and diversity training must be clearly understood and applied in practice, such that learners are able to demonstrate they meet the professional standards required of them. Equality and diversity training must be appropriately monitored, and learners and educators must be up-to-date with their training.

Learner's health and wellbeing; educational and pastoral support (R3.2)

- 68** Medical students said if they had any pastoral or performance issues they know exactly who to contact as it's signposted very well by QUB. QUB also has counselling services. Students said they have an option of who to talk to as they have a year lead and pastoral lead.
- 69** Foundation doctors and doctors in training said that there is a drive to look after yourself, and some said they could discuss wellbeing with their educational supervisor.
- 70** Doctors in training who had required pastoral support said the trust referred them to NIMDTA. We heard that they felt very well supported by NIMDTA.
- 71** Foundation doctors said they felt pressure to come in when unwell due to rota gaps. They said they receive calls from HR asking when they are due to come back if they

are unwell. Foundations doctors felt this made it difficult to observe a period of quarantine, for example (48hrs) after an infectious gastrointestinal illness.

Requirement 2: The organisation and distribution of the rota for junior doctors in training must be reviewed by the trust. The design of the rotas must also be reviewed in order to minimise the adverse effects of fatigue and workload, and undue pressure felt by the doctors in training to attend their shift when unwell.

72 We heard from doctors in training in O&G that where they have been involved in a patient death, they received support from their consultants and perinatal psychologist. The case is also discussed at a multidisciplinary team meeting where they speak about how they feel about the incident. The doctors in training valued the support from the consultants and midwifery sisters. They also said NIMDTA provides support to them under these circumstances.

Area working well 5: Following serious untoward incidents in obstetrics and gynaecology there was support from midwives and specialist psychologists for doctors in training, in addition to supervisor support.

Undermining and bullying (R3.3)

73 Medical students said they had not experienced undermining and bullying at the trust and would feel comfortable to raise something with QUB if they were in this situation.

74 Most doctors in training we spoke with feel they can raise undermining and bullying concerns to a number of different consultants but said they had not been required to. We also heard that there is a mentor scheme within the trust and junior doctors could raise any concerns of undermining and bullying behaviours to a more senior doctor in training through this forum if necessary. Supervisors felt this informal process works well but said there is a formal trust policy on raising undermining and bullying concerns and escalating to NIMDTA.

75 Some foundation doctors said they had felt under pressure to transfer patients. They sometimes felt it had been both unnecessary and unsafe. We heard that they made their concerns clear under these circumstances but that it can be an uncomfortable and undermining experience. Some foundation doctors said they would later reflect on the situation with a more senior doctor in training in order to make sure they had made the right decision in the patients' best interests. See [R2.11](#).

Student assistantships and shadowing (R3.6)

76 Foundation doctors found their final year assistantship (previously known as F0) was not long enough at nine weeks but did not have any other comments about it. They felt that their undergraduate programme at QUB could generally be more practical in order to prepare them for their foundation years. We are aware that the final year

assistantship had previously been shortened from 11 weeks to nine weeks following feedback from students to QUB that the assistantship was too long.

Information about curriculum, assessment and clinical placements (R3.7)

77 Doctors in training in T&O said their consultants 'go the extra mile' in preparing them for their Fellowship of Royal College of Surgeons (FRCS) exam. We heard that the consultants take it upon themselves to organise a mock exam where six examiners are set up in different rooms to emulate the different stations. The education management team also reflected that the doctors in training in T&O have amazing exam preparation by their consultants.

Supporting less than full-time training (R3.10)

78 We met doctors in training who are on a less than full-time training programme who had found this easy to arrange. They found NIMDTA and the trust to be supportive of this.

Support on returning to a training programme (R3.11)

79 Foundation doctors and doctors in training who had returned to training from a break said they received no support upon returning. Some found it very stressful and said HR at the trust was very difficult to work with, whilst the ward they were working in was very accommodating.

Study leave (R3.12)

80 Most doctors in training and foundation doctors said it was easy to request study leave. However doctors in training in O&G said study leave can be rejected due to rota gaps although when there are enough people in the department study leave is prioritised.

Feedback on performance, development and progress (R3.13)

81 Medical students said feedback on their exams from QUB is good and they can see how they are performing in their cohort. We also heard they can request more detailed feedback, and that if they were in the bottom 5% of their cohort this feedback would be provided anyway. The students liked that if they did something well in their OSCEs they would receive a written message (green card) informing them of this.

82 Foundation doctors said they receive a lot of feedback which can be used in their e-portfolio.

83 Doctors in core and higher training in general surgery and T&O told us they have an interim annual review of competence progression (ARCP) at NIMDTA. They find this

helpful as their remaining time in that cycle of training can be adjusted such that individual learning needs can be taken into consideration when allocating experience.

- 84** Doctors in core and higher training in general internal medicine said they receive formal and informal feedback from consultants which they find helpful.
- 85** Doctors in training in O&G said they received constructive, helpful feedback on their performance from consultants and midwives.

Support for learners in difficulties (R3.14)

- 86** We heard from the education management team that action plans are created for doctors in difficulty. These move with them to the next trust they go to, ensuring they receive the appropriate support.

Career support and advice (R3.16)

- 87** Foundation year 1 doctors said they recently had a careers session which they found to be really useful. Doctors in core training felt they would benefit from more careers advice in foundation training, particularly for those who were still unclear on which path to take. They felt a number of people take a career break in order to decide their career path as they are still undecided at the end of their foundation programme.

Theme 4: Supporting Educators

Standards

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.*

Induction, training, appraisal for educators (R4.1)

- 88** Some supervisors said they did not have a specific induction to their role as educators, but they have appraisals that include their educator role.
- 89** The education management team holds a central database of trainers' information which includes the training they have had as educators. They share the information with NIMDTA in order for the consultants to be recognised as trainers. We heard that NIMDTA quality manages the delivery of the trust's training for trainers. They receive feedback on all of their courses.

Time in job plans (R4.2)

- 90** The education management team informed us all those with a training role have time in their job plans and that NIMDTA has supported this. We heard that the supporting professional activities (SPA) time is due to be increased in trainers' job plans and the education management team asks the trainers to document their educator roles quite clearly so the trust can reasonably account for this. We heard from supervisors that the time received for education in their job plans is still in a transitional state.

Accessible resources for educators (R4.3)

- 91** The trust has a supervisors' information pack, but whilst some supervisors were aware of it, not all had seen it.

Educators' concerns or difficulties (R4.4)

- 92** All supervisors we met found the trust to be supportive in dealing with any concerns they have. We heard supervisors meet as a group to discuss concerns and can escalate things to the trust and to NIMDTA. They feel that concerns they raise are dealt with appropriately.

Recognition of approval of educators (R4.6)

- 93** Supervisors said a lot of work had been undertaken with NIMDTA in order for them to be recognised as trainers. They are all now formally recognised for their educational roles.

Theme 5: Developing and implementing curricula and assessments

Standard

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

Training programme delivery (R5.9)

- 94** Doctors in training in T&O all spoke positively of their experience at the trust, including preparation for assessments where their consultants 'go above and beyond'. They feel it is a really solid educational programme, and said they 'inherit the good experience they've received and give back'. In the 2016 NTS results, Musgrave Park Hospital had green outliers for 12 of the 15 indicators, including clinical supervision, induction, handover and feedback. This supports the positive view of the doctors in training we met at the trust.
- 95** The education management team also recognised the strong educational experience for doctors in training in T&O and said the consultants in the department are mindful that the doctors in training are there primarily for education.

Area working well 6: We heard in trauma and orthopaedics that consultants role-modelled excellence in medical education and that this is then emulated by doctors in training.

- 96** Doctors in training in the trust recognised they receive a different experience working in this trust compared with other trusts in Northern Ireland - this being due to its size, location and the tertiary services provided. All felt they were able to meet the competencies required by their curricula

Area working well 7: Clinical exposure is good. Doctors in training are obtaining sufficient practical experience to achieve the clinical competencies required by their curricula.

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