General Medical Council

Visit Report on Health Education England working across the East Midlands

This visit is part of the East Midlands regional 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	Health Education England working across the East Midlands (HEE EM)
Sites visited	HEE EM local office – Ruddington
Local education providers visited in the region	Sherwood Forest Hospitals NHS Foundation Trust – 14 October 2016 Nottingham University Hospitals NHS Trust - 20 October 2016 Circle Nottingham NHS Treatment Centre – 21 October 2016 University Hospitals of Leicester NHS Trust – 25 October 2016 Kettering General Hospital NHS Foundation Trust – 26 October 2016 United Lincolnshire Hospitals NHS Trust – 17 & 18 November
Medical schools visited in the region	University of Nottingham Medical School – 3 and 4 November 2016 University of Leicester Medical School – 9 & 10 November

	2016
Programmes reviewed	Foundation, core medical training, gastroenterology, emergency medicine, acute internal medicine, general internal medicine, cardiology and anaesthetics.
Date of visit	1 & 2 December 2016
Overview	We visited Health Education England working across the East Midlands (HEE EM) as part of our regional review of medical education in the East Midlands. During the review we visited six local education providers (LEPs) and two medical schools. The visit to HEE EM was our last visit as part of this series of visits in the East Midlands region. During our visit, we met with HEE EM senior management and quality teams, trainee representatives, training programme directors (TPDs), heads of school (HoS), lay representatives and the pastoral support team. The geography of HEE EM spans across the East Midlands and includes Derbyshire, Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottinghamshire. In the past, all training programmes were split into the North (including Nottingham, Derbyshire and Lincolnshire) and the South (including Leicestershire and Rutland and Northamptonshire). HEE EM has recently made moves to combine some programmes across the whole region. This report contains areas of good practice and areas working well for HEE EM that we found on our visit to the organisation, as well as our visits to LEPs and medical schools in the region. It also contains recommendations where improvements can be made, and requirements where standards are not being met.*

* Disclaimer: This report reflects findings and conclusions based on evidence collected prior and during the visit.

Areas of good practice

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

Number	Theme	Good practice
1	Theme two (R2.1, R2.6); Theme four (R4.5)	HEE EM's current quality structure ensures robust, proportionate quality management across the local area, with a good oversight of potential and new issues and support of directors of medical education. See paragraphs 15-17; 43
2	Theme three (R3.2, R3.14)	We were impressed with the work carried out by the professional support unit. In particular, we welcome the pilot to proactively identify those who may need support at recruitment rather than being reactive to problems later. See paragraphs 30-33

Areas that are working well

We note areas 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 one (R1.1, R1.22)	The HEE EM team is supportive with a culture of caring and collaboration to drive improvements to education and to patient safety. See paragraphs 2 & 3
2	Theme two (R2.3)	We welcome the involvement of lay members in many of HEE EM's processes. See paragraph 22
3	Theme two (R2.8)	We heard good examples of specialty schools learning from departments in difficulty to make more effective interventions in other

		departments. See paragraphs 24 & 25
4	Theme four (R4.5)	The support offered by the postgraduate dean to heads of school and directors of medical education at LEPs is welcome. DMEs felt supported by HEE EM to make improvements to training and appreciated the opportunity to share experiences across the DME network. Heads of school were also very appreciative of the support and training offered to them. See paragraph 44

Requirements

We set requirements where we have found that our standards are not being met. Each requirement is:

- targeted
- outlines which part of the standard is not being met
- mapped to evidence gathered during the visit.

We will monitor each organisation's response and will expect evidence that progress is being made.

Number	Theme	Requirements
1	Theme one (R1.7, R1.12)	HEE EM must continue to monitor and work with LEPs to address the impact of rota gaps and workload on clinical supervision and the delivery of education and training. See paragraphs 4 & 5; 8
2	Theme one (R1.12, R1.16)	HEE EM must support LEPs and Local Workforce Action Boards (LWABs) to develop a more long-term and sustainable solution to rota gaps across the region that avoids adverse educational impact that non training grades may have on doctors in training posts.

		See paragraph 9
3	Theme three (R3.12)	HEE EM must address access to study leave across the region to ensure that there are no impediments to doctors in training taking required study leave. See paragraphs 36-38

Recommendations

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

Number	Theme	Recommendations
1	Theme one (R1.10)	HEE EM should share good practice and introduce a region wide approach to identifying learners at different stages of their training. See paragraph 7
2	Theme two (R2.3, R2.5)	We recommend that HEE EM enhance their quality processes and innovations by greater sharing and analysis of data. This is particularly true of equality and diversity data, which HEE EM should collect to analyse the impact of its processes on different groups of trainees. See paragraphs 20 & 21
3	Theme two (R2.8)	We recommend that HEE EM continues to work with medical schools to streamline their quality visits as much as practical. See paragraph 27
4	Theme four (R4.2)	HEE EM should look at the variation in tariff for educational SPAs and how this could be amended to improve recruitment and retention of educational supervisors. HEE EM may wish to consider looking at the size and shape of the faculty of educational supervisors with

		protected time in their job plans. See paragraphs 41 & 42

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', e.g. 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); Supporting improvement (R1.22)

1 During our visits to local education providers (LEPs) in the region, we found that generally the learning environment is positive and doctors in training are informed how to, and encouraged to, report concerns about patient safety. Whereas, in many LEPs, individual feedback is not given to doctors in training who raise concerns, we did hear of good examples of sharing lessons learned more generally, for instance in mortality and morbidity meetings.

2 During our visit to Health Education England working across the East Midlands, we found that the postgraduate team is supportive with a culture of caring and collaboration. For example, in 2014 HEE EM changed their quality management visits system, engaging with LEPs in the region to ensure that their voice was heard and the new system had support. We heard from LEPs in the region how much HEE EM's role in quality managing training is appreciated. HEE EM informed us that their close relationships with LEPs in the region allow them to quickly learn about patient safety concerns involving doctors in training. They also investigate reporting systems as part of their quality management visits.

3 We heard examples from our visits to LEPs of HEE EM offering good support to departments facing difficulties. For instance, we heard from University Hospitals of Leicester NHS Trust of HEE EM providing guidance to make improvements to training in their emergency department, which was in enhanced monitoring. These improvements are now sustainable and training in the department has been used as a good example for others.

Area working well 1: The HEE EM team is supportive with a culture of caring and collaboration to drive improvements to education and to patient safety.

Appropriate capacity for clinical supervision (R1.7)

4 On our visits to LEPs in the region we found that generally, learning environments were safe for patients and supportive for medical students and doctors in training with appropriate clinical supervision. However, we did hear examples of how service pressures and staffing levels are impeding the supervision and workload of some doctors in training. We heard that rota gaps are prevalent across the region and that recruitment into certain specialities and geographical areas is challenging.

5 During our visit to HEE EM we heard that there are issues with low occupancy rates throughout the region. We also heard how last minute rota gaps can leave LEPs with insufficient notice to address these properly. The training programme directors we met told us that there is currently no mechanism to prevent a lot of vacancies in different specialties in an LEP occurring at the same time. This can have a big impact on smaller district general hospitals.

Requirement 1: HEE EM must continue to monitor and work with LEPs to address the impact of rota gaps and workload on clinical supervision and the delivery of education and training.

Identifying learners at different stages (R1.10)

6 Doctors in training and staff in the region repeatedly used the terms 'senior house officer', 'SHO' and 'registrar'. They had a common understanding that 'SHO' can include doctors in second year of foundation training (F2), doctors in the first and second years of core medical training, and doctors in the first few years of specialty training. The term 'senior house officer' or 'SHO' is ambiguous for doctors in training, members of the multidisciplinary team, and patients, as it does not specify the level of training of the individual doctors. Furthermore, doctors in training could be asked to work beyond their competence or without adequate supervision.

7 We heard at University Hospitals of Leicester NHS Trust that they have introduced lanyards with different colours representing medical students, consultants and doctors at different stages in their training. We also understand that this may have been initially introduced by another trust in the region. We also saw doctors in training who had kept their lanyards when working in a different trust, thus making the colour coding incorrect. In order to prevent this, and to more clearly identify learners at different stages, HEE EM should introduce these lanyards consistently across the region.

Recommendation 1: HEE EM should share good practice and introduce a region wide approach to identifying learners at different stages of their training.

Rota design (R1.12); Protected time for learning (R1.16)

8 We heard that rota gaps across the region are impacting on clinical supervision and opportunities for learning. We also heard of different initiatives in LEPs to address these gaps to ensure that the training of doctors and patient safety is not affected. These initiatives include appointing trust grade doctors in Nottingham University Hospitals NHS Trust and University Hospitals of Leicester NHS Trust, using nurse educators to provide some training in Sherwood Forest Hospitals NHS Foundation Trust and developing bespoke training programmes in Kettering General Hospital NHS Foundation Trust to facilitate professional development for trust grade doctors and, if appropriate, help them prepare for entry to the specialist register through Article 14.

Requirement 1: HEE EM must continue to monitor and work with LEPs to address the impact of rota gaps and workload on clinical supervision and the delivery of education and training.

9 It is encouraging to see LEPs proactively addressing rota gaps and their impact on training. We did hear examples where non-training grade doctors have made a substantial contribution to specialties with difficulties recruiting, such as emergency medicine at Kettering. However, the issue of rota gaps must be addressed at a regional level, coordinated by HEE EM. We heard that the cohort of non-training grade doctors is not a long-term and sustainable solution to rota gaps across the region, as these doctors can regularly move between different, competing, trusts. We also heard that there is a perception that bespoke training programmes for non-training grade doctors can compete with official training programmes for doctors, risking instability in training programmes in the region.

Requirement 2: HEE EM must support LEPs and Local Workforce Action Boards (LWABs) to develop a more long-term and sustainable solution to rota gaps across the region that avoids adverse educational impact that non training grades may have on doctors in training posts.

Induction (R1.13)

10 HEE EM has introduced an e-induction for all doctors in training to use before working at a new trust. The quality team at HEE EM told us that this was introduced to address region-wide evidence that inductions were not sufficient. The induction package is completed by doctors in training before they start work, meaning much of the face-to-face trust induction is not required. This has been implemented differently in different LEPS, with some offering time off in lieu to compensate for time taken to complete it. We did hear from doctors in training that many of the induction areas are not necessary as they have been completed in previous inductions, this can make the induction take several hours to complete. However, we understand that the intention is to carry over generic elements of the induction so they are not repeated unnecessarily. For the future, it is an HEE aspiration to align the e-induction with other regions which might help doctors in training if they move regions.

Handover (R1.14)

11 Handover arrangements vary between LEPs, and between departments. Kettering General Hospital NHS Foundation Trust and Sherwood Forest NHS Foundation Trust are introducing an electronic handover system, and there is already such a system in place at Nottingham University Hospitals NHS Trust and University Hospitals of Leicester NHS Trust, although not in all departments. We found issues with handover in all trusts we visited, although this was often limited to particular departments or shifts.

Capacity, resources and facilities (R1.19)

12 Clinical skills resources at University Hospitals of Leicester have previously been reported to be a problem in the Dean's Report for a number of years. HEE EM has worked with University Hospitals of Leicester and Leicester Medical School to build a new, state-of-the-art, clinical skills unit, which was praised by medical students and doctors in training. We also heard how Nottingham University Hospitals NHS Trust, Sherwood Forest NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust have invested in educational resources and facilities in the last few years.

13 We heard that IT systems at University Hospitals of Leicester NHS Trust are very old and slow. There are multiple log-ins for different systems and often these log ins are shared, making it, for example, unclear who has issued a prescription. We also heard that systems at Kettering General Hospital NHS Foundation Trust do not allow doctors to view trends in bloods results. At Pilgrim Hospital in United Lincolnshire Hospitals NHS Trust, doctors in training have reported insufficient blood gas machines for a number of years.

Access to educational supervision (R1.21)

14 All doctors in training we spoke to had been allocated a named educational supervisor and the majority had not had any problems meeting with them. Some doctors did express that sometimes their educational supervisor can be based in a different trust, making it harder to arrange a meeting. Doctors in this situation were able to arrange meetings with their supervisors but many had to take time off to do so.

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); Systems and processes to monitor quality on placements (R2.6)

15 HEE EM's quality management visits process was reviewed in 2013/14, following extensive engagement with stakeholders. HEE EM's model of quality management relies on close relationships with LEPs in the region, providing support and guidance to LEPs to make improvements to training and empowering Directors of Medical Education to quality control training locally.

16 Quality management visits to LEPs take place annually. Each LEP completes a quarterly self-assessment, mapped to Health Education England's quality framework. These self-assessments are triangulated with other evidence and discussed with the LEP in a teleconference in March. HEE EM then selects, in collaboration with the LEPs, which specialties to focus on, and determines the level of the visit. HEE EM then explains this to the Chief Executive Officer and the visit takes place around the autumn. The level of the visit reflects the risks identified and this decision is signed off by the Postgraduate Dean's senior team. Higher risk visits will involve more senior members of the postgraduate team, and the highest risk visits will be attended by the General Medical Council and may lead to cases entering the Enhanced Monitoring process.

17 HEE EM also undertakes regular programme reviews, and tries to ensure that small specialties are included in LEP visits. Where a LEP or specialty has problems that cannot easily be resolved locally, HEE EM provides guidance. For example, in emergency medicine at Sherwood Forest Hospitals NHS Foundation Trust, which is currently in enhanced monitoring, HEE EM provided a guidance and support package, suggesting exactly which changes needed to be made to resolve issues. HEE EM reports that this guidance has had a positive impact on training in this specialty.

Good practice 1: HEE EM's current quality structure ensures robust, proportionate quality management across the local area, with a good oversight of potential and new issues and support of directors of medical education.

Accountability for quality (R2.2)

18 The majority of the LEPs we visited demonstrated strong educational governance structures. University Hospitals of Leicester and Kettering General Hospital both have appointed non-executive board members responsible for education. This was encouraging to see, and HEE EM told us how this role had made a positive difference in another LEP. University Hospitals of Leicester takes a systematic approach to the management of education using the analysis of dashboards to define key indicators for the state of education and training throughout the trust. At Sherwood Forest we heard how educational issues have been reported to the Board and addressed. In Kettering, cognisant of the impact services pressures have on medical education, the Workforce Strategy Group, a sub-committee of the board, works closely with the Medical Director and Director of Medical Education to consider and plan ongoing workforce initiatives. Nottingham University Hospitals has recently undergone staff changes in the education management and the new team plans to strengthen the reporting lines from the Learning and Education Committee to the Board and introduce a comprehensive education report to be available to the trust board regularly.

19 Within HEE EM there is a clear quality framework to escalate issues. The Postgraduate Dean is the senior responsible officer and can escalate issues to the Director of Education and Quality at Health Education England. There are also regular quality forums where issues can be shared and discussed. Each specialty school reports to the Quality Scrutiny Board (QSB), which ensures that standards are met and looks at issues across specialty schools. The QSB membership includes Associate Postgraduate Deans, the Head of Quality, lay representatives, doctor in training representatives, and medical school representatives. The results of the quality scrutiny board are shared and reviewed by heads of school as a group, so they can share learning, good practice and risks.

Considering impact on learners of policies, systems, processes (R2.3); Collecting, analysing and using data on quality and on equality and diversity (R2.5)

20 We heard that HEE EM have made, and are making, a lot of changes to their process. For instance, they have changed how they undertake quality management visits and are looking at making the professional support unit (PSU) more proactive. Whereas these innovations are positive, we recommend that more data is collected and analysed to access, and demonstrate, the impact of these changes.

21 This is particularly true of equality and diversity data, which is not routinely collected and analysed. For example, we heard that many referrals to the PSU are from international medical graduate (IMG) doctors and that, as a result, HEE EM has planned additional support resources. Analysis of equality and diversity data will help measure the effectiveness of this additional support.

Recommendation 2: We recommend that HEE EM enhance their quality processes and innovations by greater sharing and analysis of data. This is particularly true of equality and diversity data, which HEE EM should collect to analyse the impact of its processes on different groups of trainees.

22 We heard how HEE EM makes good use of lay partners in many of their processes. There is lay involvement in the Quality Scrutiny Board, quality visits, recruitment and selection panels, and Annual Review of Competence Progression (ARCP) panels. Their role on these panels is to challenge panel chairs if they feel doctors in training are not being treated fairly and to ensure that decisions are supported by evidence and related to the curriculum. Lay partners receive specific training for their role, including unconscious bias training and go through a formal recruitment process.

Area working well 4: We welcome the involvement of lay members in many of HEE EM's processes.

Concerns about quality of education and training (R2.7)

23 The majority of doctors in training told us during our visits that they raise any concerns about their education and training through their educational supervisors. We also heard how LEPs use junior doctors' forums and local surveys to collect feedback. Training programme directors and heads of school told us that educational supervisors escalate issues to them where appropriate.

Sharing and reporting information about quality of education and training (R2.8)

24 We heard from heads of school that HEE EM uses learning from departments in difficulty to identify risks earlier and make more effective interventions in other departments. We heard how the Head of School for emergency medicine worked with the Emergency Department at Kettering General Hospital NHS Foundation Trust to make sustainable improvements to training there. They were then able to use this learning to identify another department at risk of having the same issues. This early identification of risk led to an early intervention into the department, at Sherwood Forest Hospitals NHS Foundation Trust, and progress is now being monitored via the GMC enhanced monitoring process.

25 We also heard that, in medicine, HEE EM have appointed a lead for 'red-flag' specialties, who shares expertise on how to support specialties where there are high levels of concern around training. This lead offers support to trainers, doctors in training and training programme directors. The lead also works closely with the HEE EM quality team, and has contributed to quality visits. The lead has recently been part of HEE EM's programme review of Clinical Oncology and also helps share good practice across the region. This role is particularly useful in medicine where there are a large number of different specialties and there may not be specific knowledge of how to address serious problems within the specialty itself.

Area working well 2: We heard good examples of specialty schools learning from departments in difficulty to make more effective interventions in other departments.

26 HEE EM told us that the postgraduate dean regularly liaises with Nottingham and Leicester medical schools. From January 2017 there will be monthly meetings, specifically to discuss the outcomes of service level agreements with LEPs. All parties agreed that there is a good collaborative relationship between HEE EM and the two schools, with early discussion of common issues.

27 The LEPs we visited expressed a desire for HEE EM and the medical schools to combine their quality visits as much as possible, to lessen the burden on LEPs. We heard how medical schools used to attend postgraduate visits but they stopped this as they wanted more of an undergraduate focus. Whereas the medical schools stated that attending a purely postgraduate focussed visit may not be the ideal solution, it may be possible to combine visits with a focus on postgraduate and undergraduate education. We heard from University of Nottingham Medical School that they plan to combine visits with HEE EM.

Recommendation 3: We recommend that HEE EM continues to work with medical schools to streamline their quality visits as much as practical.

Managing concerns about a learner (R2.16)

28 We heard how HEE EM has introduced a serious concerns group, which is an advisory group to the responsible officer. This group was set up to support trusts where there is a potential fitness to practice concern about a doctor in training. Rather than leaving any referral decision down to individuals in LEPS, this group can provide advice on whether referral to the General Medical Council is required.

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.*

Learner's health and wellbeing; educational and pastoral support (R3.2); Support for learners in difficulties (R3.14)

30 We heard how the professional support unit (PSU) at HEE EM is supporting doctors who are having difficulties with their training. The unit now only accepts referrals from educational supervisors. The PSU made this change in order to prevent self-referrals around problems they cannot help with. Each referral is risk assessed and if other avenues of support are more appropriate the doctor is referred on, for example if there is a specific health issue.

31 The unit provides a lot of work-based coaching to doctors to enable them to address issues themselves. The aim of the unit is to be an educational support service rather than addressing health issues. Of those doctors referred with problems passing exams, two thirds go on to pass these exams following coaching.

32 The PSU has piloted an initiative with general practice trainees called 'perfect day' which offers coaching to doctors who fail clinical skills assessments. This involves videoing consultations and providing detailed feedback, and is based on self-regulation theory. This initiative was in its second year when we visited. Of those who used the service in the first year, 75% percent went on to pass their assessments. The unit is looking at expanding this service to doctors training in all specialties.

33 The PSU analyses referrals they receive to identify trends. For example, there were a high number of referrals for exam issues in radiology. The unit worked with the head of school to offer study support training at the beginning of the training programme. The unit is looking to expand this to all specialties and identify those who may need help at recruitment so that support is offered proactively rather than being reactive to problems later.

Good practice 2: We were impressed with the work carried out by the professional support unit. In particular, we welcome the pilot to proactively identify those who may need support at recruitment rather than being reactive to problems later.

Undermining and bullying (R3.3)

34 HEE EM informed us that reports of undermining and bullying are taken very seriously and responded to very quickly. Quality managers will visit an LEP based on these reports and work with the LEP to resolve any issues. HEE EM uses anonymous voting technology, Turning Point, to collect feedback on undermining concerns when

meeting with groups of doctors in training. This is used most prominently when there are existing concerns about bullying and undermining behaviour.

35 The majority of doctors in training we spoke to in our visits did not report any concerns. However, we did hear of isolated examples in departments which we have picked up in the trust reports. We also heard from medical students at University Hospitals of Leicester about comments from consultants advising certain careers due to their gender or ethnic background and belittling certain career choices in comparison to others. For example, female students were advised not to follow certain surgical careers due to their perceived lack of physical strength or their need to have a family which would distract them.

Study leave (R3.12)

36 During our visits to LEPs in the region we heard mixed reports from learners on difficulties accessing study leave. In some LEPs and specialties this was not a problem but in others it was difficult to have study leave approved, due to demands on the rota. We also heard from some doctors in training that the system used to request leave is overly complex.

37 We heard from trainee representatives during our visit to HEE EM that the approval system has many different approval stages, making it hard to gain approval in time. Furthermore, trainee representatives told us that it can be difficult to claim money back for study leave taken. It is also difficult to apply for leave more than six weeks in advance as rotas are not always available in time; this can risk leave not being approved in time. Requests for study leave go to rota co-ordinators in the trust, and there are no service level agreements for how long requests take to process. We also heard that the difficulties in using the system has discouraged doctors in training from applying for study leave.

38 Heads of school told us that trust have different procedures and rules on claiming for study leave, meaning it can be difficult to claim money back for study leave taken. Efforts are being made to improve consistency across the region. Training programme directors also told us that study leave budgets are administered within trusts, rather than centrally through HEE EM. This means there is less flexibility to pay for more expensive courses required during specialty training.

Requirement 3: HEE EM must address access to study leave across the region to ensure that there are no impediments to doctors in training taking required study leave.

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)

40 At all LEPs we visited, educators are provided with training and are appraised on their role. HEE EM has developed, together with the University of Nottingham, an online training programme, called MEDWISE, for supervisors. We heard that at Nottingham University Hospitals NHS Trust, all educational supervisors have completed this course. Other LEPs may use different training programmes, but they are all quality assured by HEE EM and all recognised trainer have completed accredited training. HEE EM currently runs an educators day, but now this will be moved to an online package. HEE EM has also put in place awards for educators and has received many nominations. Educators we spoke to in LEPs appreciated this recognition.

Time in job plans (R4.2)

41 In our visits to LEPs in the region we heard of the variation in time in educators' job plans. In United Lincolnshire Hospitals NHS Trust educational and clinical supervisors receive 0.125 SPA (supporting professional activities) time per each doctor in training whereas in Nottingham University Hospitals NHS Trust educators receive a standard 0.5 SPAs for their clinical and educational supervision duties regardless of the number of doctors in training they supervise. At Kettering General Hospital NHS Foundation Trust educational supervisors receive 0.25 PAs per doctor in training up to a maximum of 0.5 PAs, however we were told that some consultants were supervising more than two doctors in training.

42 A bigger issue educators raised was the ability to actually protect this time in job plans. In Nottingham University Hospitals NHS Trust, the allocated time was not sufficient and educators often had to do e-portfolio work in their own time. During our visit to HEE EM, we heard from heads of school and training programme directors that, across the region, using time allocated was difficult. Heads of school told us that the variability in PAs and difficulty using allocated time meant that there was a risk that consultants would not want to take on such roles in future. These issues of variation and difficulty accessing time may be resolved by developing a smaller faculty who have more protected time, rather than trying to ensure time is protected in a large number of educational supervisors' job plans.

Recommendation 4: HEE EM should look at the variation in tariff for educational SPAs and how this could be amended to improve recruitment and retention of educational supervisors. HEE EM may wish to consider looking at the size and shape of the faculty of educational supervisors with protected time in their job plans.

Working with other educators (R4.5)

43 We heard on our visit that the postgraduate dean's approach to driving improvements in local education providers is to invest in educational leadership in these providers. On our visits to LEPs we heard that directors of medical education were appreciative of the support offered by the postgraduate dean. We were particularly pleased to hear of the DME's network, where DMEs in the region get together quarterly, along with HEE EM, to discuss issues and share good practice.

Good practice 1: HEE EM's current quality structure ensures robust, proportionate quality management across the local area, with a good oversight of potential and new issues and support of directors of medical education.

44 We also heard from heads of school that they attend regular meetings together with the HEE EM quality team. Heads of school receive good training and development from HEE EM, with a bespoke leadership course and workshops taking place throughout the year. They also appreciated their involvement with the quality team. Heads of school have been much more involved in quality visits in recent years and have triggered visits based on intelligence they have gathered.

Area working well 3: The support offered by the postgraduate dean to heads of school and directors of medical education at LEPs is welcome. DMEs felt supported by HEE EM to make improvements to training and appreciated the opportunity to share experiences across the DME network. Heads of school were also very appreciative of the support and training offered to them.

Recognition of approval of educators (R4.6)

45 HEE EM told us that they gave all LEPs their data on the recognition of trainers so they are aware of their progress in completing this data. The data was used by HEE EM in their quality visits. This data is currently saved on different systems depending on the LEP, but it will all be migrated to intrepid shortly. HEE EM has confirmed that their list of recognised trainers is complete.

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.*

Informing curricular development (R5.2); Undergraduate clinical placements (R5.4)

46 At the time of our visits, both Leicester and Nottingham medical schools were developing new curricula and HEE EM confirmed that they have had input into both. There are regular meetings between the quality team at HEE EM and the medical school quality teams where information is shared about the quality of training in clinical placements, amongst other issues. Leicester Medical School's new curriculum will focus much more on general practice placements, and HEE EM have offered advice on how this transition should be managed.

Training programme delivery (R5.9)

47 On our visits to LEPs across the region, we heard examples of where providing service and accessing educational opportunities were imbalanced. At Kettering, foundation doctors and core doctors in training were not able to clerk patients. At Sherwood Forest, most doctors in training we spoke to stated that workload affects their training and teaching experience at the trust and noted that at times learning is secondary to service provision. At Lincolnshire there were some concerns about the balance between service and training for doctors in foundation training in emergency medicine at Pilgrim Hospital and in core medical training at Lincoln County Hospital. In Leicester, F2 doctors shared their fear of not meeting the 70% attendance threshold for teaching sessions, especially those working on busy medicine wards that could not always be released to attend teaching.

48 In their evidence submission, HEE EM told us that they assess the quality of all specialty schools (including foundation) through their quality scrutiny board. The QSB asks about any curriculum mapping exercises and any configuration of posts within the programme. The quality team also told us that they investigate curriculum delivery during their quality visits. They have identified problems such as core trainees not attending training sessions and have ensured these were resolved. The quality team also initiate programme reviews where there are common issues across a training programme in the region. We heard that there had been a recent programme review into clinical oncology.

Mapping assessments against curricula (R5.10)

49 During our visit, HEE EM told us how they are analysing their annual review of competence progression (ARCP) outcomes. They had identified the need to provide some training for ARCP panel chairs on their role, responsibilities and the support they can get from HEE EM, before, during and after ARCPs. After each ARCP panel HEE EM looks at what went well and what didn't and devise new training and implement improvements. This approach appears to have had an effect, with HEE EM now receiving fewer complaints about ARCP outcomes. HEE EM told us that, in the past, around 80% of appeals against non-standard ARCP outcomes used to be overturned, this has now dropped to around 20%. We did not see this analysis as part of HEE EM's evidence submission. It is hoped that this analysis and training will make outcomes more consistent across specialty schools.

50 As previously stated in para 18, lay representatives have been appointed and trained specifically to challenge ARCP panel chairs and to ensure that processes and decisions are consistent and fair. Heads of school told us that they found the ARCP chair's teaching very useful.

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