

Visit Report on Kettering General Hospital NHS Foundation Trust

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	Kettering General Hospital NHS Foundation Trust
Sites visited	Kettering General Hospital
Programmes	Foundation, core medical training, acute internal medicine, anaesthetics, cardiology and general internal medicine
Date of visit	26 October 2016
Overview	<p>Kettering General Hospital has approximately 600 beds and is run by Kettering General Hospital NHS Foundation Trust. The hospital serves a population in the region of 300,000 and covers an area including Northamptonshire, South Leicestershire and Rutland. The trust provides placements for medical students from University of Leicester Medical School.</p> <p>The most recent CQC visit to the hospital took place in February 2016 when a focused inspection was conducted to review urgent and emergency services and medical care (including older people's care).</p> <p>Overall we found an open, supportive training environment within the trust. Educational governance is working well and the trust board takes an active interest in matters pertaining to education and training. As with many hospitals however, staffing issues and the resultant conflict</p>

between training and service provision present a number of challenges. We identified several areas requiring improvement including clinical supervision, handover and feedback.*

* 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, R2.2)	<p>The trust is committed to education and training with clear, transparent educational governance systems and structures in place as well as a strong educational team. The trust displays clear accountability for educational governance at a trust board and directorate level which includes the engagement of the lead non-executive director for education.</p> <p>See paragraphs 33-35</p>

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 (R1.3)	<p>Quality improvement projects and the patient safety lessons learnt forum are positive developments. We encourage the trust to continue promoting this more widely to ensure doctors in training attend the forums and engage fully in these initiatives.</p> <p>See paragraphs 6 & 7</p>
2	Theme one (R1.22)	<p>There is a supportive and open culture at Kettering General Hospital with an enthusiasm for teaching and learning amongst the learners and trainers. Improvements have been made in the emergency department especially in regard to the culture and team-building.</p> <p>See paragraphs 30-32</p>
3	Theme four (R4.4), (R4.5)	<p>The development of the educational lead roles and support for educators has led to a clear</p>

		positive impact in the trust, for example the improvements in the emergency department. See paragraph 56
4	Theme five (R5.4)	The trust is a good environment for delivering the undergraduate curriculum. Foundation year one doctors teaching medical students is positive and is well received by the students. See paragraph 58

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)	The trust must investigate gaps in rota to ensure learners have adequate supervision, working patterns, workload, learning opportunities, and for patients to receive care that is safe and of a good standard. See paragraphs 12 & 13
2	Theme one (R1.13)	The trust must make sure that all learners have an induction in preparation for each placement. See paragraph 19
3	Theme one (R1.13)	The trust must ensure doctors in training do not have to share IT login information with locum personnel.

		See paragraph 20
4	Theme one (R1.14)	<p>The trust must ensure that handover of care is strengthened and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.</p> <p>See paragraph 21</p>

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 two (R2.5)	<p>The Trust should consider how it can analyse and use the data it collects on equality and diversity to evaluate learners' performance, progression and outcomes.</p> <p>See paragraph 37</p>
2	Theme three (R3.13)	<p>The trust should ensure that learners receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.</p> <p>See paragraphs 49 & 50</p>
3	Theme two (R2.10); Theme four (R4.2)	<p>The trust should monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.</p> <p>See paragraph 55</p>

4	Theme five (R5.9)	<p>The trust should ensure that clinical placements give doctors in training a balance between providing service and training opportunities. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out of hours cover that do not support learning and have little educational or training value.</p> <p>See paragraph 61</p>
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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)

- 1** Health Education England working across East Midlands (HEE EM) undertook a quality management visit to the trust in Nov 2015 following which a recommendation was made with regard to the raising and investigation of concerns. An action plan detailing the trust's response to this recommendation was submitted ahead of this visit. Although lacking detail, the action plan did make reference to training courses planned for early 2016 and we saw evidence of scheduled training events available to all staff.
- 2** During the visit it became apparent that the trust does actively encourage learners and educators to report patient safety concerns. Both the medical students and doctors in training we met with confirmed that, during their trust induction, they had received guidance with regard to raising patient safety concerns via Datix, the patient safety reporting system in use within the trust, and that they felt comfortable in doing so.
- 3** Not all concerns are reported via Datix as some are reported informally to other members of staff (see requirement R1.5). We heard examples of learners being encouraged to report patient safety concerns directly to their educational or clinical supervisors or other senior members of staff. We were also told that doctors in training are encouraged to raise any concerns they have via the trainee doctors' forum – a monthly meeting chaired by the medical director.

- 4 Some of the doctors in training we met with were unaware of the process for investigating concerns and often those who had submitted a concern did not receive formal feedback.

Learning from mistakes (R1.3)

- 5 When a concern is raised the trust does take steps to learn from mistakes and we heard of a number of initiatives that enable staff to reflect on incidents or near misses.
- 6 A Patient Safety Lessons Learned forum is held once every two months to discuss serious untoward incidents and 'never events'. This multi-disciplinary event is open to all and doctors in training are encouraged to attend. Educators and learners who do attend are asked to disseminate information to those not present however this appears to be an informal process.
- 7 We also heard that Datix reports are discussed at some departmental morbidity and mortality meetings. A summary of the discussions together with any learning outcomes are minuted and disseminated to team members however, again, this appears to be an informal arrangement.

Area working well 1: Quality improvement projects and the patient safety lessons learnt forum are positive developments. We encourage the trust to continue promoting this more widely to ensure doctors in training attend the forums and engage fully in these initiatives.

Seeking and responding to feedback (R1.5)

- 8 Many of those we met appeared reluctant to use the Datix system, preferring instead to raise concerns directly to a colleague or more senior member of staff. The main reason for this appeared to be lack of feedback. We heard several examples whereby a concern had been submitted via Datix however there had been no feedback with regard to the ensuing investigation or subsequent outcome. Where concerns had been raised via an educational or clinical supervisor we found that feedback was variable. There was a perception amongst those we spoke to that action was more likely to be taken to address a concern if the concern had been raised either to an individual or at the junior doctors forum.
- 9 We heard that an upgrade to the Datix system has recently been undertaken. Those who submit a concern now receive an email acknowledgment and are able to track progress. Whilst there is currently no facility to record whether a concern has been raised by a medical student or doctor in training, the trust will review whether, going forward, it is possible to do so. This will enable the medical education team to identify and assist doctors and/or medical students involved.

Educational and clinical governance (R1.6)

- 10** Medical students and doctors in training we met with were fully aware of the need to raise concerns about the quality of care and we heard examples of individuals doing this. All those we met with knew how to submit a concern via Datix despite, as detailed above, on occasion being unwilling to do so. We heard that the trust employs surveys to gauge awareness and understanding of local protocols.

Appropriate capacity for clinical supervision (R1.7); Appropriate level of clinical supervision (R1.8)

- 11** Throughout the visit many of the doctors in training we met with spoke of a helpful and supportive environment within the trust. We heard that the consultant body is approachable, enthusiastic and keen to teach and, for many of those we met, clinical supervision is of a good standard and readily available.
- 12** As with many hospitals however, increasing workload brings additional pressures and challenges and we heard how, in some specialties, rota gaps are impacting on clinical supervision. Specifically we heard of issues whereby doctors in training are sometimes left unsupervised whilst more senior colleagues undertake duties such as theatre, ward or lab work.
- 13** We heard further examples of how rota gaps are affecting clinical supervision with mention being made of doctors in training being supervised by locum consultants or trust grade doctors, some of whom are unfamiliar with specific training requirements.

Requirement 1: The trust must investigate gaps in rota to ensure learners have adequate supervision, working patterns, workload, learning opportunities, and for patients to receive care that is safe and of a good standard.

- 14** Hospital at Night was introduced in August 2016 and those we met spoke favourably about the impact this had within the trust.

Appropriate responsibilities for patient care (R1.9)

- 15** No concerns in this area were raised during the visit. Doctors in training we met with confirmed that they do not work beyond their level of competence and are not pressurised to do so.

Rota design (R1.12)

- 16** As with many hospitals, rota gaps continue to be an on-going issue. Whilst attempts are made to recruit permanent members of staff, this is not always possible. Where rota gaps do occur, locum doctors are employed and we were told that the trust does make some effort to maintain continuity by employing locums on long term contracts or by employing locum doctors that have worked within the trust previously.

- 17** Over the course of the visit we learned that issues relating to rota gaps varied between training grades and between specialties, with some doctors in training being affected more than others. We heard that where rota gaps do exist this can have a negative impact on education and training as service needs take priority. Despite this, we heard that attendance at regional teaching events is encouraged however attendance at local teaching appears more sporadic.

Induction (R1.13)

- 18** The trust operates an e-learning induction package, a link to which is sent out to new employees two weeks before starting in post. Those we spoke to found the information basic but adequate.
- 19** The majority of those we met confirmed that they had also received a departmental induction and this coincided with information received ahead of the visit. Generally, departmental inductions were considered to be both useful and informative, although it was apparent that the content and structure varied between specialties. We heard that, on occasion, it was possible for doctors to take up post without having undertaken a departmental induction. For some this was because they had been rostered to begin their placement at night.

Requirement 2: The trust must make sure that all learners have an induction in preparation for each placement.

- 20** We heard from doctors in training that locum doctors new to the trust do not receive system log-ins immediately upon taking up post but instead, use log-in details belonging to permanent members of staff. This presents both a risk to patient safety and is an information governance concern and was raised with the education management team on the day of the visit.

Requirement 3: The trust must ensure doctors in training do not have to share IT login information with locum personnel.

Handover (R1.14)

- 21** We heard that the trust is in the process of introducing an electronic handover system but many of the people we met during the visit referred to a paper based process. Handover takes place in the morning, late afternoon and to the hospital at night team. Consultant presence at handover appeared variable according to time and specialty. On a number of occasions we heard that handover is less structured in the late afternoon and that this had already been identified as an area requiring improvement.

Requirement 4: The trust must ensure that handover of care is strengthened and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.

Educational value (R1.15)

22 We heard that, where rota gaps exist, service provision takes priority and this can lead to missed training opportunities. We heard a number of examples where doctors in training were not being given the opportunity to clerk patients but were instead being asked to perform routine non-educationally valuable tasks. This appeared to vary between specialties. We heard that, where possible, trainers are encouraged to identify and discuss learning opportunities as and when they occur although the need for formal teaching arrangements is also recognised.

Protected time for learning (R1.16)

23 We were informed prior to the visit that weekly teaching sessions are planned for throughout the year enabling doctors to meeting curriculum requirements. During the visit we heard that for some, these sessions will be bleep free.

Adequate time and resources for assessment (R1.18)

24 It is apparent that work place based assessments are being carried out however we heard that on occasion and often due to the pressures of work, the level of feedback can be variable.

Capacity, resources and facilities (R1.19)

25 Generally, facilities were considered by those we met with to be adequate, however we did hear some concerns with regard to IT systems. Specifically, these centred on the blood reporting system which does not include the option to view trends. In order to do so, doctors in training have to transcribe results and this introduces the risk of error.

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

26 We heard from the director of medical education that money from central funding (see R2.1 & R2.2) has been used to improve simulation facilities and that a simulation lead had been appointed. The senior management team, doctors in training and their supervisors made reference to the improvement in simulation facilities and we understand that additional funding is being sought to improve facilities further still.

Access to educational supervision (R1.21)

27 The trust advised us that all doctors in training have a named educational supervisor and this was confirmed by those we met during the course of the visit.

28 We heard that not all educational supervisors are on site and that some doctors in training have an educational supervisor based in Leicester, as some supervisors are allocated by programme not post. Despite this, there does not appear to be a

problem with access to educational supervision, with doctors in training being given time to meet with educational supervisors as and when needed.

Supporting improvement (R1.22)

- 29** We heard that many improvements have been made to training in emergency medicine. The emergency department (ED) has had long standing issues with the quality of training and with recruitment. This resulted in higher specialty doctors in training temporarily not being placed in the department and regional teaching not being delivered there.
- 30** We found that the ED team were cohesive and supportive with an enthusiasm for teaching and learning amongst the learners and trainers. One trainer was an education lead with responsibility for arranging teaching whilst another had responsibility for delivering a training programme for non-training grade doctors.
- 31** Doctors in training described the ED as really supportive and that they would recommend it for training. The workload can be high but there is good support from consultants, nurses and other departments. The workload can impact on attending formal teaching but trainers ensure that lots of informal, opportunistic teaching takes place and attempt to deliver more formal teaching whenever possible.
- 32** Trainers we spoke to described how a lot of work has gone into improving the education culture in the ED. They were particularly pleased that HEE-EM has recently agreed to reintroduce regional teaching to the department. They also praised the support they received from the director of medical education in delivering improvements.

Area working well 2: There is a supportive and open culture at Kettering General Hospital with an enthusiasm for teaching and learning amongst the learners and trainers. Improvements have been made in the emergency department especially in regard to the culture and team-building.

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); Accountability for quality (R2.2); Considering impact on learners of policies, systems, processes (R2.3)

- 33** Education and training is considered a key area of focus within the trust. We heard that a non-executive director has been appointed with a specific responsibility for monitoring and reporting issues affecting medical education to the trust board. This appointment serves to bridge a divide - ensuring that factors affecting medical education and training are brought to the attention of the board on a regular basis whilst at the same time providing those in senior education roles with some insight into the day to day issues faced by the board with respect to service delivery.
- 34** The trust faces issues in relation to current and future service needs within the local area and the possible need for service reconfiguration. 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.
- 35** We heard that the trust medical education committee meets once a month and is chaired by the director of medical education. In addition to considering issues relating to the delivery and quality management of education, we heard that the committee has achieved a degree of financial autonomy by securing central funding for key projects.

Good Practice 1: The trust is committed to education and training with clear, transparent educational governance systems and structures in place as well as a strong educational team. The trust displays clear accountability for educational governance at a trust board and directorate level which includes the engagement of the lead non-executive director for education.

Evaluating and reviewing curricula and assessment (R2.4)

- 36** The trust medical education team discusses and identifies solutions to issues affecting both undergraduate and postgraduate medical education and training. We heard that where concerns have been identified (for example, through the GMC National Training Survey or via student feedback), the trust works closely with HEE EM or Leicester Medical School to make sure that they fully understand the issue and, together, can decide the best way forward.

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

- 37** We heard that whilst the trust does collect data on equality and diversity data it is not used to monitor progression or to inform change.

Recommendation 1: The Trust should consider how it can analyse and use the data it collects on equality and diversity to evaluate learners' performance, progression and outcomes.

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

- 38** Doctors in training described raising their concerns with regard to education and training either directly to their educational or clinical supervisor or to the junior doctor forum. Minutes from the junior doctor forum were reviewed ahead of the visit and, where concerns were documented, it was not immediately clear who was responsible for taking some of the items forward or the timeframe for resolution.
- 39** The trust employs local surveys to gauge opinion and to identify areas for improvement. Prior to the visit we saw evidence of this specifically with regard to induction and supervisor feedback. End of placement surveys are also completed by medical students and doctors in training. For medical students, analysis of the end of placement questionnaire is conducted by Leicester Medical School and we heard, from students, examples of changes that had taken place as a result of this feedback.
- 40** A quality improvement lead has recently been appointed with a view to improving the quality management of medical education and training within the trust. Throughout the course of the visit we heard mention of a number of quality improvement initiatives, however these were not reviewed in detail.

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

- 41** HEE EM is responsible for quality managing education and training within the trust and we heard that there is a close working relationship between the two organisations. We both heard and saw evidence of a quality management visit together with the ensuing action plan.
- 42** Whilst educational governance measures are in place within the trust we saw little evidence of the trust voluntarily sharing information with external stakeholders

including, where appropriate, examples of good practice; although this may take place informally.

Educators for medical students (R2.13)

- 43** The trust employs an undergraduate lead to oversee the training of medical students on site. We also heard that a deputy undergraduate lead role had been created. Medical students we met with suggested that if they had concerns with regard to their placement they would raise these either with Leicester Medical School or the administrator responsible for the undergraduate programme based at the trust.

Managing concerns about a learner (R2.16); Sharing information of learners between organisations (R2.17)

- 44** Prior to the visit we saw evidence that the trust medical education committee have a standing item on their monthly agenda to discuss doctors in difficulty. In a supporting statement submitted ahead of the visit, the trust also advised that there is a continuous process of collecting information, evaluating performance and sharing information both for medical students and medical trainees however we did not see any confidential documentation to support this statement.

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

45 Prior to the visit we were advised that a satellite pastoral support service was being developed on site for students and doctors in training and that, in the interim, the deputy undergraduate lead had taken up this role for students and foundation programme directors offer a confidential pastoral support service for doctors in training. It would appear that this is a recent initiative as no documentation was provided detailing these arrangements ahead of the visit or on the day of the visit itself.

Undermining and bullying (R3.3)

46 Many of those we met, whether medical students, doctors in training, educators, or members of the management team, spoke of a friendly and supportive environment within the trust and we did not hear any concerns to suggest endemic bullying or undermining.

Student assistantships and shadowing (R3.6)

47 Foundation doctors confirmed they had undertaken a period of shadowing prior to taking up post. The trust confirmed that the shadowing period is four days however some of those we met would have liked this to have been longer. The shadowing period includes a trust and departmental induction as well as clinical skills training. None of those we met had undertaken their period of shadowing at night despite some starting their first placement on night shift.

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

48 We heard that applications to work less than full time are agreed by HEE EM and accommodated within the trust on a case by case basis.

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

49 Feedback for doctors in training appeared variable and, as often occurs where there are rota gaps, was dependent on the availability of staff. For some of those we met, constructive feedback was given on a regular basis however this did not appear to be the case for everyone.

- 50** Some doctors in training told us that they find it difficult to obtain immediate feedback after a learning activity which they thought was due, in part, to the high workload.

Recommendation 2: The trust should ensure that learners receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.

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)

- 51** We heard that approximately two thirds of all consultants employed by the trust have a recognised educational and/or clinical supervisory role. Consultants not currently occupying one of these roles are encouraged to do so in order to spread the workload. Prior to the visit we saw evidence of e-Portfolio courses available to trainers and on the day we heard details of an e-portfolio/WPBA workshop that had been held. The trust confirmed that records are kept of training undertaken by educational and clinical supervisors and we both heard and saw evidence of this during the visit.
- 52** We heard that educational roles are reviewed as part of the routine appraisal process and that only those with more senior educational roles are appraised separately against their educational responsibilities.

Time in job plans (R4.2)

- 53** In addition to providing clinical care, consultants also undertake supporting professional activities (SPAs). At Kettering General Hospital consultants are assigned 1.5 SPAs within their job plans in recognition of activities that support their clinical role.
- 54** We heard from some that, like other trusts in the region, those who undertake an educational supervisor role receive a further 0.25 SPA per doctor in training up to a maximum of 0.5 SPAs. This would suggest that each educational supervisor is accountable for up to two doctors in training but we heard that it is sometimes more than this. Others believed that the educational supervisor role attracted 0.125 SPAs per doctor in training up to a maximum of 0.25 SPAs.
- 55** We also heard that whilst the clinical supervisor role is formally recognised within the trust, it does not attract additional SPAs. It was apparent that there is some confusion amongst the consultant body with regard to the trust policy on this issue and further clarification is required. Trainers must have enough time in their job plans to meet their educational responsibilities and we explored this issue at our visit to HEE EM.

Recommendation 3: The trust should monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.

Educators' concerns or difficulties (R4.4); Working with other educators (R4.5)

56 In order to improve educational governance, a number of education lead roles have been created within the trust. This role, which is formally recognised in job plans and attracts SPAs, has been created to support the implementation, management and development of training programmes. Supporting the work of college tutors, educational leads feed directly into the monthly medical education committee meeting. Nine appointments have been made to date serving a number of different departments and specialties.

Areas working well 3: The development of the educational lead roles and support for educators has led to a clear positive impact in the trust, for example the improvements in the emergency department.

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.*

Undergraduate clinical placements (R5.4)

- 57** We heard that prior to starting their placement, medical students are sent a link to an online induction which they complete before taking up placement and are given a further half day induction including a tour of the hospital and facilities upon arrival at the trust.
- 58** Medical students we met with were enjoying their time at Kettering General Hospital and spoke favourably about the teaching provided both by doctors in training and the consultant body. Particular reference was made to the teaching provided by foundation doctors however students recognised the service pressures faced by all those involved in teaching and were appreciative of the efforts made on their behalf.

Area working well 4: The trust is a good environment for delivering the undergraduate curriculum. Foundation year one doctors teaching medical students is positive and is well received by the students.

- 59** In the main, the medical students appeared confident that they will achieve the learning outcomes required of them however we did hear that a small number of outcomes are associated with procedures not undertaken within the trust. We also heard one or two examples whereby students did not have access to certain clinics however this appeared to be due to scheduling issues and was not an on-going concern.
- 60** Whilst students spoke of multidisciplinary learning taking place within the confines of their medical school, the opportunity to learn with other health and social care professionals at the trust appeared to be limited.

Training programme delivery (R5.9)

- 61** Both medical students and doctors in training cited examples whereby learning opportunities are being missed due to competing work pressures. On a number of occasions we heard that clerking of patients is undertaken by doctors in higher training rather than doctors in foundation or core medical training who, instead, are left to undertake less educationally valuable tasks.

Recommendation 4: The trust should ensure that clinical placements give doctors in training a balance between providing service and training opportunities. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out of hours cover that do not support learning and have little educational or training value.

Team leader	Prof Paul O'Neill
Visitors	Prof Anoop Chauhan Ms Katherine Marks Prof Peter McCrorie Prof Alastair McGowan
GMC staff	Mrs Kim Archer Mr Kevin Connor Ms Abigail Nwaokolo

Department of Medical Education

Rothwell Road

Kettering

Northants

NN16 8UZ

Mr Kevin Connor
Education QA Programme Manager
General Medical Council
Regent's Place
350 Euston Road
London
NW1 3JN

Main Switchboard: 01536 492000

Direct Dial: 01536 491124

Web: www.kgh.nhs.uk*When calling, please ask for Medical Education Manager*

04 May 2017

Dear Mr Connor,

We would like to thank the GMC for a detailed review on learning and education within our Trust. We found the report accurate.

We were pleased the GMC recognised and highlighted the areas of good practice which are proving to be working well. This will provide us with an opportunity to build a positive culture of training and education within the Trust and receive continued support at a Trust Board level.

The GMC Report also highlighted some areas that require support. We will ensure that these areas are discussed widely within the Trust to ensure we achieve high quality training and education. Our responses to these requirements are below:

- 1) **“The Trust must investigate gaps in rota to ensure learners have adequate supervision, working patterns, workload, learning opportunities, and for patients to receive care that is safe and of a good standard.”**

We acknowledge that along with other Trusts within the region there have been rota gaps which have impacted on work load, working patterns and learning opportunities.

Addressing rota gaps is one of the Trust's highest priorities. We are working closely with HR and Business Unit Directors. However, recruitment to middle grade vacancies continues to be a challenge. We have successfully recruited to some of these posts and continue our efforts to address rota gaps. We are working with a group of junior doctors to review the rotas to maximise efficiency and reduce the impact and number of gaps. We have appointed clinical assistants to release doctors from performing tasks of minimal training value, allowing the trainees to enhance their learning opportunities.

The Trust has good numbers of trained Educational and Clinical supervisors recognised by the GMC.

2) “The Trust must make sure that all learners have an induction in preparation for each placement.”

We have enhanced the departmental inductions across the Trust. All trainees receive an induction at the beginning of each placement. We recognise that a small number of trainees may miss the initial induction due to being on-call or off. Procedures are now in place to capture these trainees to ensure they receive an induction. The 2016 GMC survey highlighted improvements previously made to induction within the Trust. We also have appointed Education Leads within all departments to quality control the departmental induction including updates, records of attendance and feedback.

3) “The Trust must ensure doctors in training are not sharing IT login information with locum personnel.”

Emergency login packs are available for locum doctors out-of-hours, and we are working closely with HR and IT to reinforce the use of these packs across the Trust.

We have communicated via email and at the Junior Doctor Forum that trainees are not to share their IT login details. We are also developing a PC screen saver to reiterate this across the Trust.

4) “The Trust must ensure that handover of care is strengthened and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.”

Morning handover is multi-professional, led by a consultant and a senior nurse. This has received good feedback from Health Education England Working across the East Midlands (HEE-EM).

Evening handover is being strengthened by utilising the matron from Hospital at Night to lead the handover. The longer term plan for the Trust is to have a Consultant present on site up until 10pm. They will lead handover along with the matron.

The GMC feedback will be shared widely within the Trust including management, trainees and trainers to ensure full support throughout the Trust in enhancing Medical Education.

Yours Sincerely,



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Dr Syed Fayyaz Hussain
Director of Medical Education