

## Visit report on Northern Ireland Medical and Dental Training Agency

This visit is part of the Northern Ireland 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

<b>Organisation visited</b>	Northern Ireland Medical and Dental Training Agency (NIMDTA)
<b>Date of visit</b>	28 and 29 March 2017
<b>Local education providers visited</b>	Belfast Health and Social Care Trust Northern Health and Social Care Trust South Eastern Health and Social Care Trust Southern Health and Social Care Trust Western Health and Social Care Trust
<b>Programmes</b>	<ul style="list-style-type: none"> <li>■ Foundation</li> <li>■ Cardiology</li> <li>■ Core medical training (CMT)</li> <li>■ Core surgical training (CST)</li> <li>■ Emergency medicine</li> <li>■ General (internal) medicine (GIM)</li> <li>■ General practice</li> <li>■ General surgery</li> <li>■ Obstetrics and gynaecology (O&amp;G)</li> <li>■ Paediatrics</li> <li>■ Trauma and orthopaedics</li> </ul>
<b>Overview</b>	NIMDTA is responsible for the training of medical and dental professionals in Northern Ireland. It organises the recruitment and allocation of doctors in training to foundation, core and specialty training programmes. There

are five integrated health and social care trusts in Northern Ireland each containing several hospitals (known as local education providers). NIMDTA works closely with local education providers to deliver the training and supervision of doctors in training while supporting the delivery of safe patient care.

During the visit we met with NIMDTA’s senior and quality management teams, representatives for doctors in training, lay representatives, heads of schools, training programme directors, the professional support unit team and doctors in training involved in the ADEPT (Achieve Develop Explore Programme for Trainees) and VALUED (Voice is listened to, Applaud & acclaim success, Life-work balance, Up to date & high quality training, Enhanced learning opportunities and Distinctive) programmes and mentoring schemes.

We felt that this was a positive visit. It was clear that NIMDTA is working well with implementing the *Promoting Excellence* standards. This was mapped into their guidance and documentation for education and training.

We heard there has been a steady decrease in recent years in the number of doctors remaining in and applying for specialty training. This has had implications for the service, producing rota gaps. NIMDTA has put in considerable strategic effort to try to encourage recruitment and retention of doctors in training.

## 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 1: Learning environment and culture ( <a href="#">R1.2</a> )	Patient safety reports are being used for educational intervention and are shared amongst all levels and specialties of doctors in training.
2	Theme 1: Learning environment and culture ( <a href="#">R1.22</a> )	The ADEPT programme is well organised, integrated into training and provides opportunity to gain good leadership skills. This was valued by doctors in training. The ADEPT

		fellows we met appreciated the Dean's direct involvement and his accessibility.
3	Theme 2: Education governance and leadership ( <a href="#">R2.12</a> )	The lay representatives working with NIMDTA have considerable expertise, bringing a positive degree of scrutiny and externality to proceedings. They felt a valued part of the team and their feedback influences change.

### 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 1: Learning environment and culture ( <a href="#">R1.22</a> )  Theme 3: Supporting learners ( <a href="#">R3.2</a> )  Theme 4: Supporting Educators ( <a href="#">R4.1</a> )	We recognised that NIMDTA has a culture of making people feel valued which ranged from doctors in training, future leaders (ADEPT fellows) and educators, particularly heads of schools.
2	Theme 2: Education governance and leadership ( <a href="#">R2.8</a> )  Theme 4: Supporting Educators ( <a href="#">R4.5</a> )	There is a strong collaboration between NIMDTA and Queen's University Belfast School of Medicine which provides a linear continuum of medical education. This relationship also allows positive influences on training through transfer of information.
3	Theme 3: Supporting learners ( <a href="#">R3.5</a> )	There are areas where transitions between stages of training are being managed well. We heard of examples from undergraduate to foundation programme, ST2 to ST3 in obstetrics and gynaecology, and the 'registrar ready' programme in medicine.
4	Theme 3: Supporting learners ( <a href="#">R3.13</a> )	We heard good feedback that the ARCP process was working well from doctors in training, training programme directors and lay representatives.

## 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.

NIMDTA has no requirements from this visit.

## 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 2 Education governance and leadership ( <a href="#">R2.5</a> ) Theme 3 Supporting learners ( <a href="#">R3.1</a> )	There is insufficient understanding and awareness of equality and diversity amongst the learners and educators we met at NIMDTA and LEPs. NIMDTA should maximise the use of data to inform their E&D work.
2	Theme 2: Education governance and leadership ( <a href="#">R2.6</a> ) Theme 5: Developing and implementing curricula and assessments ( <a href="#">R5.9</a> )	NIMDTA should continue to work with LEPs to ensure that posts are aligned to the best training opportunities. This is to ensure service delivery is not prioritised over training, and doctors in training receive the experience and support they require, in posts they regard as attractive.

## 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); Educational and clinical governance (R1.6)*

- 1** We were told by heads of schools (HoS) and training programme directors (TPDs) that the way patient safety issues are addressed and the thresholds for local reporting varies across Local Education Providers (LEPs). We noted from NIMDTA's whistleblowing policy that it clarifies the circumstances and processes by which doctors in training should raise issues and states that the LEP should be the first point of contact. NIMDTA's senior management team said that they encourage doctors in training to raise concerns with their clinical supervisors in the first instance.
- 2** Doctors in training we met across all LEP sites said they felt comfortable in approaching senior doctors to raise any concerns they had. There seemed to be a general hesitation in using the formal processes to raise concerns. We heard of variation in methods of formally reporting concerns at each LEP, which ranged from using the incident reporting system Datix, to the LEP's own paper and online reporting process. Doctors in training must know how to raise any concerns formally about the quality of care and should be encouraged to engage in these processes.

#### *Dealing with concerns (R1.2)*

- 3** There has been a decrease in the number of patient safety comments raised to the GMC via the National Training Survey (NTS) from doctors in training across Northern Ireland. We heard that guidance is given to doctors in training by NIMDTA prior to completing the NTS, encouraging them to raise concerns locally before being raised

in the NTS. All patient safety comments are followed up with respective LEPs through the NIMDTA quality management process. The response timelines for these are indicated in NIMDTA's *Quality Management Processes for Postgraduate Medical Training* document.

- 4 We were told by the senior management team that issues with the behaviour or practice of doctors in training at the LEPs are raised to the postgraduate dean by the medical director of the trust in order for NIMDTA to follow up at their quality management group.
- 5 We heard from senior management team that maximising the use of lessons learnt following incidents is being developed at NIMDTA. More senior doctors in training or HoS summarise patient safety reports which are then distributed amongst the schools and included in the NIMDTA newsletters for doctors in training.

**Good practice 1:** Patient safety reports are being used for educational intervention and are shared amongst all levels and specialties of doctors in training.

- 6 HoS and TPDs in obstetrics and gynaecology mentioned that learning from incidents is a process embedded within their teaching and told us of examples of how data from incident reporting is shared within the specialty. We were also told that a serious untoward incident (SUI) e-learning module is being rolled out as mandatory for all doctors in training in obstetrics and gynaecology.
- 7 In summary, we heard that concerns are being escalated appropriately to NIMDTA and that NIMDTA is taking action to address and monitor the issues that are raised.

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

- 8 We heard across multiple LEPs that the clinical supervisors for doctors in training are supportive and accessible.
- 9 During the visits to the LEPs, issues were identified with foundation doctors not having appropriate clinical supervision arrangements at Northern HSCT, Western HSCT and South Eastern HSCT. All foundation doctors must at all times have on-site access to a senior colleague that is suitably qualified to address any issues that may arise. NIMDTA is aware of the issues and is working with the trusts through their quality management framework.

*Rota design (R1.12) and Educational value (R1.15)*

- 10 We heard from HoS and TPDs that they find that rota gaps and increasing numbers of locums are the main challenges in the working environment, although we were told by the TPDs that teaching and clinics get priority where possible when rotas are

designed. During some of the LEP visits we heard that due to service pressures teaching is being affected.

- 11** The senior management team informed us that the increasing number of training post vacancies have meant there has been an increase in locums to maintain service. Some doctors do not go into specialty training after foundation training and instead become a locum, believing they have more flexibility. LEPs also noted to us that they are struggling with this, as it affects the numbers of doctors in training and work planning. NIMDTA has introduced the VALUED (Voice is listened to, Applaud & acclaim success, Life-work balance, Up to date & high quality training, Enhanced learning opportunities and Distinctive) strategy to encourage doctors in training to remain in training. The intention is to make training across Northern Ireland more enticing. We were told that NIMDTA does not control the whole budget for all training posts, but would like to move to a situation where it does so. They told us of their plans to create quality indicators for each specialty and create fewer and higher value training posts, but this is currently challenging.
- 12** The LEP site visits all noted strains on training due to the ongoing and increasing service pressures. Some LEPs are struggling with the service and training balance while others (GP programme and South Eastern HSCT) have systems and processes in place to ensure that training is protected, and balanced with service provision. We would encourage NIMDTA to continue to look at what is working well within the GP training programme and South Eastern HSCT and share good practice in rota design, through its partnership with other trusts and agencies.
- 13** Although NIMDTA is not responsible for rota design they may set out guidelines for how this should work across the trusts. If LEPs have problems meeting the GMC standards, NIMDTA advises in this area or suggests work with an LEP where rotas work well. We heard an example of this at the Northern HSCT where NIMDTA provided advice to help with the issues with the medicine rota at Causeway Hospital by sharing rotas from other LEPs that were working well.

#### *Induction (R1.13)*

- 14** We heard from doctors in training, trainers, and programme directors about the NIMDTA Foundation programme induction, which was well-received and a good opportunity for new doctors to prepare for clinical practice.

#### *Protected time for learning (R1.16)*

- 15** We heard a mixture of views at our LEP visits from various specialties about being able to attend teaching. Overall doctors in training felt that this is not a problem but there were instances where, due to service demands or staff shortages, they are not able to attend. We heard that work is being done by educators across the LEPs to ensure that teaching is protected.

- 16** The quality management team (QMT) at NIMDTA said that there is a set amount of teaching that doctors in training have to attend. However, we heard if this is not met due to valid reasons, the doctor in training would not be penalised and there would be no effect on their Annual Review of Competence Progression (ARCP) outcome. It was not clear how NIMDTA's quality management team use this information to ensure the quality management of specialty training. NIMDTA should ensure doctors in training are able to attend educational sessions to meet the requirements of their curriculum.
- 17** TPDs told us that if doctors in training cannot access mandatory teaching they intervene to see what can be done. Attendance is monitored through teaching logs. Doctors in training told us at the LEP visits that teaching scheduled in Belfast is sometimes difficult to attend for those not in the Belfast HSCT, and that videolinks do not always work.
- 18** We heard that doctors in training provide feedback on their regional teaching days run by NIMDTA. NIMDTA acts on feedback gathered; following recent feedback one of the days was removed as it did not provide the necessary support and educational value to the learners.

#### *Capacity, resources and facilities (R1.19)*

- 19** We heard from the quality management team about the accessibility and good quality of their video conferencing facilities which allows access to teaching for doctors in training further out of Belfast and in more remote environments in Northern Ireland. However, we did hear at the Western HSCT that doctors in core training in general internal medicine (GIM) said they used a video link from South West Acute Hospital to NIMDTA for some training but that this has not been working for a couple of months.

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

- 20** NIMDTA is working with simulation leads in each of the LEPs. This is an area being developed which was highlighted in the NIMDTA *Specialty Review into Simulation Based Training* document. A survey was undertaken by doctors in training on the current simulation arrangement to assess what equipment they can access. We were told that the results from the survey and NIMDTA's own work has found there is an extensive range of equipment on offer for simulation but that these are underutilised due to lack of available time and training. This was also reflected at the LEP visits where the majority of doctors in training told us they are aware there is equipment for simulation training but that it is not timetabled for them. This contrasts with the situation for students who generally had positive experiences of simulation at the LEPs.
- 21** We heard about the quality 2020 strategy where NIMDTA hopes to raise the profile for simulation teaching, supporting various centres to get this put in place. NIMDTA is

currently mapping curricula and looking at where simulation is a requirement e.g it is mandatory within the medicine curriculum. The NIMDTA *Specialty Review into Simulation Based Training document* is currently mapped to the respective curricula and assessment structures of the specialty programmes which was a useful and thorough review with appropriate curricular alignment.

### *Supporting improvement (R1.22)*

- 22** At our visit we spoke to doctors in training that were undertaking the Clinical Leadership Fellows' programme known as ADEPT (Achieve Develop Explore Programme for Trainees). This is a one year programme where senior doctors in training work in an apprenticeship model with senior leaders in host organisations throughout Northern Ireland.
- 23** The ADEPT fellows we met were from a range of specialties including paediatrics, psychiatry and general practice. They said they heard about the programme at roadshows and open evenings where the Dean gave a talk promoting it.
- 24** We heard about various projects the ADEPT fellows are working on including quality improvement in primary care, simulation development, and developing a regional inter-professional course. We heard that they are given broad themes and have the flexibility to mould this according to their own interests. They have a monthly meeting as a cohort which the Dean attends and they feel able to raise any issues or questions to him directly. The fellows felt that NIMDTA and the Dean himself has good oversight of their work and gives all the necessary support with a light touch approach which they welcomed.
- 25** The ADEPT fellows felt that the programme gave value to their time out of clinical training. They said that it increased their confidence, resilience, and articulation. They mentioned that the programme gave them new insight into the development of their careers and empowered them to be good leaders and consultants of the future. The education management team at the Southern HSCT told us that they can see the value that the ADEPT programme is bringing.

**Good practice 2:** The ADEPT programme is well organised, integrated into training and provides opportunity to gain good leadership skills. This was valued by doctors in training. The ADEPT fellows we met appreciated the Dean's direct involvement and his accessibility.

- 26** At the visit we heard from a spectrum of educators that they feel well supported and appreciated by NIMDTA in their role and are encouraged to take forward any initiatives related to education. HoS said that NIMDTA provides a good level of support. See R4.1 for more detail.

**Area working well 1:** We recognised that NIMDTA has a culture of making people feel valued which ranged from doctors in training, future leaders (ADEPT fellows) and educators, particularly heads of schools.

## 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)*

- 27** NIMDTA's model of quality management is outlined in their *Learning and Development Agreement* which sets out the obligations between NIMDTA, the GMC and the LEPs. NIMDTA relies on a close relationship with its LEPs, and provides support and guidance based on *Promoting Excellence* standards to make improvements to training delivery through quality control processes. Mostly, the education management teams we met during the LEP visits said they had a good working relationship with NIMDTA.
- 28** NIMDTA's quality management visits comprise of a lead from NIMDTA and the specialty school, a lay representative and a foundation or general practice representative if appropriate. The trainee representatives told us they may also attend these visits if not their own specialty.
- 29** The quality management process uses external representatives from royal colleges and faculties who are also from outside of Northern Ireland. Following the visit, the royal college/faculty representatives provide feedback to NIMDTA.
- 30** Following the NIMDTA visit and report, the LEP provides an action plan. Each action is inputted into the quality management log. These will then have a risk rating assigned by NIMDTA (green, amber or red) on the basis of impact of the risk and the likelihood. Updates on the actions are to be given to NIMDTA by the LEPs every six months. We heard from the LEPs and NIMDTA that they both work closely to follow up any issues following a report.

### *Accountability for quality (R2.2)*

- 31** Once the report following a visit is finalised by the visiting team, it is shared with the medical director and director of medical education (DME) for dissemination across the

LEP. NIMDTA then monitors the actions taken through LEP quality reports which are sent twice a year by the DME. NIMDTA then has a discussion with the DME to review progress which is followed up by the quality management group at NIMDTA who close all resolved issues. Those issues that are difficult to manage at LEP level may be escalated.

- 32** We were told by the quality management team that any serious concerns raised in the LEP quality report following a QM visit that are not managed appropriately by the LEP, are escalated. This would be to the chief executive and chair of the LEP trust board and to the Regulation and Quality Improvement Authority (RQIA). At this stage an urgent meeting with the LEP may be required. If a suitable action plan is not submitted within two weeks it is then escalated to the GMC.

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

- 33** We heard from trainee representatives that if doctors in training raise any issues at the trainee forum they can easily access relevant people at NIMDTA to discuss the matter further. We were told that each specialty school has different methods of communication, either emails out to cohort, social media platforms, or meetings.

*Evaluating and reviewing curricula and assessment (R2.4)*

- 34** We heard from HoS and TPDs that training is evaluated through the NTS, local questionnaires and feedback that is given directly to supervisors from doctors in training. They told us that results from specialty exams and ARCP outcomes are also used as a form of feedback on the performance of a specialty programme. See R5.9.

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

- 35** We were told by the senior management team that whilst E&D data is collected as reflected in the NIMDTA Equality and Diversity Policy, over 50% of doctors in training decline to declare information. This makes it difficult for NIMDTA to evaluate the data purposefully, although they still try where possible from mandatory declaration areas. The senior management team informed us that that no issues have arisen from access to programmes related to protected characteristics.

**Recommendation 1:** There is insufficient understanding and awareness of equality and diversity amongst the learners and educators we met at NIMDTA and LEPs. NIMDTA should maximise the use of data to inform their E&D work.

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

- 36** The senior management team at NIMDTA said that the educational value of placements is evaluated through the feedback from doctors in training and the relevant TPDs for the specialty. If the placement is not suitable then it would be the decision of the Quality Management Group (QMG) to agree next steps, including

whether it is appropriate for that post to remain in the training programme or be reassigned. We heard that removing a training placement could be difficult as NIMDTA shares the training money for the post with the LEP, which is concerned with destabilising the service.

- 37** We heard about positive working relationships with NIMDTA at most of the site visits. Southern and Belfast HSCT said that they are able to discuss challenges with the training posts and that NIMDTA will suggest areas for improvement and keep them up to date with changes.
- 38** We were told of the imminent changes and service reconfiguration across Northern Ireland, as overseen by the Transformation and Implementation group. This group comprises the chief executives of the Health and Social Care Trusts and the Permanent Secretary at the Department of Health. We explored with NIMDTA how the issues around education and training for doctors are conveyed and advocated to this group. The special context for this being the current recruitment and retention issue. Service reconfiguration and health resource transformation may be expected to both influence and be affected by lower numbers of doctors in training. To enable the continuance of our standards in this theme we could see that close, effective and timely liaison with all parties would be needed.

**Recommendation 2 :** NIMDTA should continue to work with LEPs to ensure that posts are aligned to the best training opportunities. This is to ensure service delivery is not prioritised over training, and doctors in training receive the experience and support they require, in posts they regard as attractive.

*Managing progression with external input (R2.12) and Examiners and assessors (R5.11)*

- 39** The lay representatives we met at the NIMDTA visit came from varying work backgrounds. They bring a wide breadth of experience and are a great resource to NIMDTA. We heard that they participate in deanery visits, ARCP panels and appeals, interviews, and research panels. The lay representatives told us that their role provided an independent view and that having the opportunity to be a lay representative gave them reassurance as a member of the public on NIMDTA's processes.
- 40** We heard that the lay representatives feel their comments on visit reports and feedback on processes is appreciated by NIMDTA, telling us about changes made following their feedback, which made them feel valued. We heard that before an ARCP panel they have a thirty minute briefing so they are up to speed and made to feel included. NIMDTA also provides them with documents such as guidance on good reports, an acronym glossary, and a copy of the foundation weekly newsletter to support them in their role.

**Good practice 3:** The lay representatives working with NIMDTA have considerable expertise, bringing a positive degree of scrutiny and externality to proceedings. They felt a valued part of the team and their feedback influences change.

*Managing concerns about a learner (R2.16)*

- 41** The senior management team informed us that for any doctors in training where there are concerns on their conduct, performance or health are managed by the Trainee Review Group (TRG). This is a sub-committee of NIMDTA's quality management group. The TRG is chaired by the Associate Dean for Career and Personal Development (CPD) and has senior educators and managers within NIMDTA as well as representation from Occupational Health and Psychiatry.
- 42** TPDs liaise with the team that deal with quality management at NIMDTA about those that are struggling with training so that the Dean is aware in advance of their ARCP panel. We were told by the Professional Support Unit (PSU) that those doctors in training that receive an outcome two, three or four are given support to help address any underlying issues and to tailor an individual action plan for them.
- 43** Those doctors in training going through the trainees support process are also known to the medical director at the LEP. Information is then transferred through the process outlined in the *Learning and Development policy 2016-17* and logged formally through e-portfolios. At the Southern HSCT visit they confirmed that they receive information on those struggling through the training process prior to their arrival by NIMDTA and are supported by NIMDTA accordingly. Other clinicians we spoke with during the NIMDTA visit also confirmed that this information sharing process worked well.

*Sharing information of learners between organisations (R2.17)*

- 44** We heard from trainee representatives that if doctors in training raise any issues at the trainee forum they can easily access relevant people at NIMDTA to discuss the matter further. We were told that each specialty school has different methods of communication, either emails out to cohort, social media platforms, or meetings.

*Recruitment, selection and appointment of learners and educators (R2.20)*

- 45** Data from the recruitment process is also published annually by NIMDTA, though we heard that the demographics for doctors in training in each training programme is difficult to analyse as doctors in training may not complete this. The senior management team told us that they can analyse data where there is compulsory declaration but for other characteristics the majority of the data is missing.

### Theme 3: Supporting learners

Standard
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<b>S3.1</b> <i>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.</i>
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#### *Good Medical Practice and ethical concerns (R3.1)*

- 46** During our visits to the LEPs, when we asked both doctors in training and educators about equality and diversity (E&D), there was a general lack of awareness of relevant equality and diversity issues.
- 47** At the NIMDTA visit we heard that the senior management team are aware that there is a training need amongst their doctors in training and are going through case examples when running their E&D training programme. Trainee representatives also said that they recognised the gap in training in E&D and have been working with NIMDTA to create a short animation which gives doctors in training a basic guide of complex E&D cases and highlights where legislation is different from the rest of the UK. The senior management team told us they have received good feedback but that it was difficult to measure if there has been a change in awareness. We did not hear about this during our visits to LEPs.
- 48** From the documents submitted by NIMDTA prior to the visit, it was not clear that an awareness of E&D is embedded throughout their processes.
- 49** We heard from the senior management team about training for educators in equality and diversity that is offered online by the Health Education England London local office. Educators at the LEP visits said this training covers their needs and provides flexibility with it being online. When asked about the content of this training we did not, in general, receive a clear account.

**Recommendation 2:** There is insufficient understanding and awareness of equality and diversity amongst the learners and educators we met at NIMDTA and LEPs. NIMDTA should maximise the use of data to inform their E&D work.

#### *Learner's health and wellbeing; educational and pastoral support (R3.2) and Career support and advice (R3.16)*

- 50** The professional support unit (PSU) informed us of various projects and schemes in place for doctors in training which includes mentoring, careers advice, professional support days, welcome evenings and trust roadshows. We heard that with the

decrease of doctors in training staying in training following foundation years, these projects were put in place to support and encourage retention.

- 51** We heard that the PSU are still struggling with the perceived stigma involved in getting professional help. Doctors in training are reluctant to come forward for support. The PSU is trying to change this perception by introducing different avenues for support.
- 52** The PSU told us that they had good relations with the LEPs. They visit trusts with roadshows, where they speak to the foundation year one doctors about specialty training and careers support. They work closely with the LEPs to ensure they do not offer a service that the LEP already offers such as mentoring.
- 53** At the NIMDTA visit we spoke to doctors in training involved in the mentoring scheme available in the Northern Trust from 2016, where a more senior doctor in training is matched with a foundation doctor. We heard that they meet four or five times a year informally to provide guidance and support. The doctors in training said that the meetings would guide them as mentors as to what sort of support was required and how often to meet. They felt that being a mentor gives them an opportunity to gain skills in teaching, preparing them for when they become a consultant or GP. The trainee representatives we met spoke positively about the mentoring schemes and said it is a good way to break the perceived stigma involved in asking for help. They told us that the schemes are organised well and supported by educators.
- 54** Across a number of the LEP visits we heard that the experience of NIMDTA PSU is positive and that LEPs feel well supported by this.

### *Undermining and bullying (R3.3)*

- 55** NIMDTA has a policy on undermining and bullying which states the organisation takes a zero tolerance approach. We were told by the quality management team that NIMDTA encourages doctors in training to raise any issues related to bullying and undermining locally. However, they do offer routes for concerns to be reported directly to them if this is not possible, for example if the issue is with a supervisor or someone more senior at the LEP.
- 56** Issues related to bullying and undermining are monitored in the quality log by NIMDTAs quality management group. These issues can be identified through a variety of sources such as the NTS, ARCP, and deanery visits. We also heard from the senior management team that due to the number of doctors in training events or training at the NIMDTA office they have another opportunity to raise any issues to NIMDTA directly.
- 57** NIMDTA has noticed, more recently, that doctors in training are speaking up more than previously about perceived undermining and bullying, potentially because of increasingly pressurised working environments. NIMDTA offers generic skills training

to recognise signs of undermining and bullying and also offers resilience training. We heard that the ADEPT fellows are working on an animation (which includes aspects of E&D and undermining) for doctors in training on how to recognise undermining and give examples of cases.

### *Supporting transition (R3.5)*

- 58** We heard from trainee representatives and foundation programme directors about the welcome and meet and greet evening for those new to Northern Ireland or not from QUB. These offer a support network for day to day issues such as where to live, information on schools, and anything else that would help them to settle in. At our LEP visits not all doctors in training were aware of this welcome evening. However, this may be due the welcome evening for those new to specialty training in Northern Ireland starting in August 2016. The 'meet and greet' evening is held by NIMDTA for foundation doctors which has been running from July 2015.
- 59** At the meeting with foundation directors we were told about the meet and greet evening that happens the night before the regional induction as an opportunity for graduates not from QUB to meet NIMDTA staff. We heard that the foundation school offers a paid four day work shadowing period for all doctors starting foundation training. A further two week shadowing opportunity is offered by the Trust for graduates who did not do their assistantship within Northern Ireland which is unpaid. We were also told about the buddy system for foundation doctors being buddied up with core doctors in training in a rota to give them additional support.
- 60** Trainee representatives and doctors in training at LEPs mentioned the 'registrar ready' course for medical specialties, which helped them prepare for the start of their expanded clinical roles. They told us that this programme is effective and they felt more prepared as a result of it. We also heard from the trainee representatives that in obstetrics and gynaecology there is an increase in attrition rates, possibly due to increasing litigation, such that doctors in training are leaving the specialty. As a result, a 'step up' course has been introduced for transition from ST2 to ST3, increasing confidence for doctors in training.

**Area working well 3:** There are areas where transitions between stages of training are being managed well. We heard of examples from undergraduate to foundation programme, ST2 to ST3 in obstetrics and gynaecology, and the 'registrar ready' programme in medicine.

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

- 61** The team that deal with quality management at NIMDTA told us there was a *Less than Full time (LTFT)* policy and that every doctor in training that has applied for a LTFT post has been accommodated. The eligibility criteria for a LTFT post is outlined in the policy. No problems were reported to us during our LEP visits.

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

- 62** The team that deal with quality management at NIMDTA told us of a formal approach to those who have had a planned leave of absence, through regular meetings with supervisors and the TPD. This higher level of supervision is provided until the doctor in training is back on track with their training. We also heard that certain specialties and NIMDTA offer a mentoring scheme to help those returning to work.
- 63** At the GP Programme visit we heard from some doctors in training about the difficulties they were facing in organising keep in touch (KIT) days during, for example, maternity leave. However, the team that deal with quality management at NIMDTA for the GP programme informed us that they are unaware of issues with KIT days.

### *Study leave (R3.12)*

- 64** We heard from the team that deal with quality management at NIMDTA at the visit that when an application for study leave is requested it is analysed to see if it maps to the curriculum. If so this time will be funded by NIMDTA. If doctors in training do have difficulty in accessing study leave NIMDTA said they should contact their HoS.

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

- 65** Progression of doctors in training is monitored through their e-portfolios. The quality of the feedback is reviewed by the TPD and HoS. We also heard that interim reviews happen prior to an ARCP meeting in order to prepare the doctor in training for what outcome they are likely to receive. At the Belfast HSCT visit doctors in core and higher training in general surgery and trauma and orthopaedics told us about the interim ARCP at NIMDTA. They find this particularly helpful as their training can then be adjusted based on individual learning needs when allocating experience.
- 66** Doctors in training at the LEPs told us that they are happy with the ARCP process and the support they receive. Doctors in training we met especially valued the interim ARCP that NIMDTA offers.

**Area working well 4:** We heard good feedback that the ARCP process was working well from doctors in training, training programme directors and lay representatives.

### *Meeting the required learning outcomes (R3.15)*

- 67** We heard from the senior management team that the foundation, GP and specialty training programmes did not have concerns that their programmes were not meeting the curriculum outcomes. We were told when there are rota gaps and constraints on service, doctors in training may be spread over multiple sites in order to gain the experience needed. For example, the senior management team at Northern HSCT told us that doctors in training in obstetrics and gynaecology gain experience in both

Causeway and Antrim hospitals. Here, they complete four and eight months in each respectively to maximise the exposure they receive to clinical cases. Doctors in training in obstetrics and gynaecology we met at Causeway hospital during our visit to Northern HSCT told us they are happy with the training they receive across both sites and are well supported.

*Career support and advice (R3.16)*

- 68** NIMDTA has an iQuest programme which outlines 15 educational opportunities for generic professional capabilities (GPC), throughout specialty training. The sessions are mapped to the GPC framework and are delivered through a variety of e-learning and full or half day workshops. When we asked the trainee representatives what they thought of iQuest some felt that it was useful tool. However at our LEP visits we heard very little about the 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)*

- 69** The senior management team said NIMDTA offers various methods of support for supervisors to improve their performance through programmes such as teaching unconscious bias, teach the teacher, advanced PowerPoint skills and improving technology skills. They have also devised training for supervisors to act as mentors for other supervisors. Supervisors we met at the LEPs told us that they could attend relevant training organised by NIMDTA for their supervisor duties and valued this.
- 70** HoS and TPDs told us that they look at how supervisors are completing e-portfolio submissions for doctors in training and they then provide advice and guidance to the supervisors on how these might be improved.

### *Working with other educators (R4.5)*

- 71** The Trainee Review Group (TRG) meets monthly at NIMDTA, where doctors in training needing support are logged and rated by need. This will include those about to transfer into Foundation training from QUB. We heard that QUB provides the necessary information to NIMDTA on the doctors in training from their medical school and will liaise with NIMDTA should further information be required.
- 72** Staff from NIMDTA meet with medical directors from the LEPs on a regular basis. We were told by the senior management team that the DME is a role, jointly funded by NIMDTA and the HSCT. The DME is responsible for transferring relevant information between NIMDTA and their trust.
- 73** Information on doctors in training is still shared informally amongst educators though matters of concern are reported more formally, in accordance with the NIMDTA policy, *Management of Trainees Requiring Support*.
- 74** We noted that NIMDTA has a good working relationship with QUB, and that NIMDTA involves QUB in their Quality Management group and vice versa. We heard from the foundation school that transfer of information on QUB is working well and that they receive all the information they need to know when a foundation one doctor comes

into post. The foundation manager monitors all doctors in training with any issues to ensure attention is given locally through the DMEs and foundation programme directors at the LEP.

- 75** We heard about methods of transferring information from the foundation school to QUB where changes to the curriculum had been implemented in order to inform teaching. An example being a number of urethral injuries on catheterisation being reported at foundation level. As the majority of those in foundation training in Northern Ireland graduated from QUB, NIMDTA foundation school relayed and discussed this with QUB who improved this area of core teaching for students. This change was aligned with the medical school curriculum. This also relates to requirement R5.2

**Area working well 2:** There is a strong collaboration between NIMDTA and Queen's University Belfast School of Medicine which provides a linear continuum of medical education. This relationship also allows positive influences on training through transfer of information.

*Recognition of approval of educators (R4.6)*

- 76** The GMC team found NIMDTA's *Recognition of Trainers* policy to be clear in defining the role of an educator and appropriately mapped to GMC standards. We found that NIMDTA's *Beyond Recognition* policy goes into the detail differentiating the role of both the clinical and educational supervisor.

## 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.*

### *Fair, reliable and valid assessments (R5.6)*

**77** The TPDs we met informed us that they all sit on ARCP panels for their specialty and that they received training through a half day ARCP workshop, provided by NIMDTA. Teaching was provided on the principles of how panels are managed and conducted. There is a separate workshop on chairing skills. We were told that the panels are benchmarked according to college calibration. We heard that college tutors feedback to supervisors based on an assessment of their ARCP contribution. The reports generated are improving the standard, according to the TPDs.

### *Training programme delivery (R5.9)*

**78** Training programmes are reviewed through NIMDTA quality management processes. As well as visiting, they also look at feedback from local questionnaires, NTS and direct face to face feedback from doctors in training to supervisors and NIMDTA.

**79** We heard that a large proportion of NIMDTA training post distribution is historical, being based on service needs. It is a complex process, affecting many stakeholders, to move training posts.

**80** There is a NIMDTA allocation policy which is adhered to, which dictates where doctors in training are placed. The team that deal with quality management at NIMDTA told us that they attempt to allocate posts evenly, across Northern Ireland. However, when doctors in training apply for posts after recruitment, they give a preference list, frequently including Belfast. NIMDTA's QMT said posts in certain geographical locations in Northern Ireland or at larger hospitals are more popular with doctors in training. Given the current recruitment issues, NIMDTA tries to accommodate this to encourage doctors to remain in training. We heard from some LEPs outside of Belfast that they have training posts that have good educational opportunities and educators to support the roles but these remain vacant.

**81** We were informed by the senior management team that the allocation of doctors in training process is published and audited externally by the Business Services Organisation.

*Mapping assessments against curricula (R5.10)*

**82** We found that the NIMDTA *Guidance for Lead Educators – Annual School Review Process* specifically provides guidance for members of the ARCP panels around NIMDTA processes and what considerations need to be taken into account when deciding outcomes.

**83** The lay representatives we met at the visit said the ARCP process is working well and fairly and that they could tell that doctors in training are aware and prepared for what outcome they were aligned to receive. They also told us that NIMDTA offers necessary support following outcomes that were adverse.

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