

Visit report on Northern Health and Social Care Trust

This visit is part of the Northern Ireland National review.

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

Summary

Education provider	Northern Health and Social Care Trust
Sites visited	<ul style="list-style-type: none"> ■ Antrim Area Hospital (AAH) ■ Causeway Hospital (CH)
Programmes	<ul style="list-style-type: none"> ■ Undergraduate ■ Foundation ■ Core medical training (CMT) ■ Core surgical training (CST) ■ Emergency medicine (EM) ■ General (internal) medicine (GIM) ■ General surgery ■ Obstetrics and gynaecology (O&G)
Date of visit	17 February 2017
Overview	<p>Northern Health and Social Care Trust (hereafter referred to as the trust) comprises of three hospitals (two general hospitals and one mental health facility) as well as several community hospitals.</p> <p>We visited the two general hospitals, Antrim Area Hospital and Causeway Hospital. During our visit we met with the trust's education management team, clinical and educational supervisors, doctors in the training posts listed above and medical students from Years 3, 4 and 5 of</p>

Queen's University Belfast School of Medicine, Dentistry and Biomedical Sciences (QUB).

Overall, we found that the majority of trainers in the trust were deemed to be supportive by the learners as well as the foundation programme director. However, there are a number of areas where the trust is not meeting the standards in *Promoting Excellence*, including induction, handover and clinical supervision.

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 (R1.7 ; R1.8)	The learning environment is caring and compassionate. Trainers and supervisors were seen to be dedicated and committed to their educational roles and the majority were described as supportive and approachable both in and out of hours.
2	Theme 1: Learning environment and culture (R1.13)	Trust induction is effective in preparing doctors in training and medical students for their rotation or placement.
3	Theme 3: Supporting learners (R3.2)	We found the foundation programme director to be supportive and accessible.
4	Theme 5: Developing and implementing curricula and assessments (R5.9)	Obstetrics and gynaecology is working well across the trust. The units are functioning well and doctors in training are content in their roles.
5	Theme 5: Developing and implementing curricula and assessments (R5.9)	Doctors in higher training are obtaining sufficient practical experience to achieve the clinical competencies required by their curricula.

Requirements

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

- targeted
- 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 1: Learning environment and culture (R1.1-R1.3)	There must be a formal culture of incident reporting in place to report concerns about patient safety. The trust must ensure that learning as a result of concerns raised is facilitated across the trust through reporting mechanisms.
2	Theme 1: Learning environment and culture (R1.7-R1.8)	Foundation year one doctors in surgical posts must have appropriate clinical supervision to ensure they are adequately advised on the management of unwell patients in order to ensure that patients receive care that is safe.
3	Theme 1: Learning environment and culture (R1.14)	Handover must be organised and scheduled to provide continuity of care for patients, ensure patient safety and to maximise the learning opportunities for doctors in training.
4	Theme 1: Learning environment and culture (R1.14)	The trust must ensure that time pressures in the emergency department at Antrim Area Hospital do not impact on doctors in training completing appropriate tests for patients, nor subsequently the handover between the emergency department and the rest of the hospital.
5	Theme 1: Learning environment and culture (R1.16)	Doctors in training must have regular, scheduled and protected time for learning in order to meet their required curriculum outcomes.

6	Theme 1: Learning environment and culture (R1.19)	The trust must ensure there is adequate physical space to ensure patient confidentiality and deliver safe and relevant learning opportunities for doctors in training.
7	Theme 2: Education governance and leadership (R2.1-R2.2)	There must be formal governance structures in place to control the quality of medical education and that educational governance is represented at board level.
8	Theme 3: Supporting learners(R3.1)	Learning outcomes from equality and diversity training must be clearly understood and applied in practice, such that learners are able to demonstrate they meet the professional standards required of them. Equality and diversity training must be appropriately monitored, and learners and educators must be up-to-date with their training.
9	Theme 3: Supporting learners (R3.3)	The trust must ensure that all doctors in training are able to seek advice from a microbiologist.
10	Theme 3: Supporting learners (R3.3)	The trust must ensure that education and training is fair, based on the principles of equality and diversity and that doctors in training are not denied training opportunities based on their gender.
11	Theme 5: Developing and implementing curricula and assessments (R5.9)	Foundation doctors must receive sufficient and relevant practical experience and training to achieve and maintain the competencies required by their curriculum.

Findings

The findings below reflect evidence gathered in advance of and during our visit, mapped to our standards.

Please note that not every requirement within *Promoting Excellence* is addressed. We report on 'exceptions', eg where things are working particularly well or where there is a risk that standards may not be met.

Theme 1: Learning environment and culture

Standards

S1.1 *The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.*

S1.2 *The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.*

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

- 1 Generally, we found learners and educators feel able to raise concerns about the standard of education and training without fear of adverse consequences. Nearly all of the doctors in training that we met feel there is a culture at the trust that enables them to raise concerns comfortably, and we heard from most that raising concerns is covered during induction.
- 2 There are various mechanisms in which learners and educators can raise concerns at the trust. The education management team told us that mechanisms include: raising concerns through Datixweb and informal line management escalation such as through clinical and educational supervisors, through the foundation programme director or through the director of medical education.
- 3 The trust has recently implemented Datixweb as a formal reporting tool and the education management team told us that it is not utilised as well as intended, and this is likely due to the rapid roll out of the reporting tool. They told us that they have received feedback from doctors in training that the system is difficult and time consuming to use with some not knowing how to use the system.
- 4 Doctors in training are aware they should be raising concerns formally through Datixweb. However, when speaking with doctors in training at both sites we found discrepancies around raising concerns, with some saying they would raise concerns informally through their supervisors and others saying they would raise concerns formally through Datixweb. We also found inconsistencies with raising concerns between specialties, with O&G using the Datixweb system to report concerns formally

and the other specialties we reviewed not. Generally, doctors in training told us that the reporting tool is widely used by nursing staff.

- 5 Most doctors in training and medical students confirmed that the use of Datixweb and raising concerns is covered during their induction. However, some foundation doctors at AAH told us they have not received any formal teaching on when and how to complete a report using Datixweb. In addition, we found that learning from issues raised generally occurs informally and we were told that the output from Datixweb is often received a while after an incident has happened.
- 6 The education management team at the trust stated they are aware they need to formalise raising and escalating concerns, as well as formalising the thresholds for using Datixweb. Currently they are focussing on improving understanding of the use of Datixweb amongst learners and educators; induction is utilised as a tool to introduce doctors in training to the trust's raising concerns policies and processes. They told us there are several forums in place to allow opportunities for raising concerns and to discuss issues that have been raised, including: the feedback forum, the foundation educational group and the monthly clinical risk group. In addition, the trust has monthly governance meetings to discuss issues that have been raised.
- 7 Overall we found that while the foundations of a formal reporting mechanism are in place, the culture of formal reporting and learning through reporting mechanisms is to be developed across the trust. We have therefore set a requirement for the trust to address.

Requirement 1: There must be a formal culture of incident reporting in place to report concerns about patient safety. The trust must ensure that learning as a result of concerns raised is facilitated across the trust through reporting mechanisms.

Supporting duty of candour (R1.4)

- 8 Whilst there is no statutory duty of candour in Northern Ireland, all the doctors in training that we spoke with across both sites were aware of their duty to be open and honest with patients when issues arise. They told us the trust supports learners to be transparent with patients, and the working environment promotes a culture of honesty and integrity. They added that the trust encourages their staff to advise patients that they are able to formally complain if issues arise.

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

- 9 Despite prevalent service pressures we found the learning environment at the trust is caring and compassionate. Learners noted they are supported in their roles and the consultant body are both responsive and approachable. We have therefore identified this level of dedication as an area that is working well in the trust.

Area working well 1: The learning environment is caring and compassionate. Trainers and supervisors were seen to be dedicated and committed to their educational roles and the majority were described as supportive and approachable both in and out of hours.

10 We found discrepancies between specialties and sites in relation to the provision of clinical supervision. Whilst doctors in training in some specialties told us they are adequately supervised others noted that it is an issue. Doctors in training in emergency medicine (EM) at AAH told us accessing clinical supervision can be variable. They told us the consultants on the ward are not always contactable and there have been times when they have been required to find another consultant on a different ward. Some clinical supervisors in EM agreed that supervision is variable and told us that whilst they may not always be available on the wards, they are accessible and contactable. This supports the 2016 NTS data which highlighted a red outlier for clinical supervision and supportive environment in EM at AAH. Doctors in training in other specialties such as obstetrics and gynaecology told us supervision is working well at AAH and the ward is well staffed.

11 During the visit we found that clinical supervision of foundation year one (F1) doctors at AAH can at times be inadequate and has resulted in F1 doctors working beyond their competence. We heard examples of F1s completing the post take ward round with no consultant or senior doctor present. We were also told about instances where F1 doctors have difficulty getting senior support to advise them on the management of unwell patients. We have therefore set a requirement around this for the trust to address.

Requirement 2: Foundation year one doctors in surgical posts must have appropriate clinical supervision to ensure they are adequately advised on the management of unwell patients in order to ensure that patients receive care that is safe.

Appropriate responsibilities for patient care (R1.9)

12 Generally we found that most learners' responsibilities for patient care are appropriate for their stage of learning. The education management team told us levels of competence, confidence and experience are discussed with doctors in training at the initial meeting with clinical and educational supervisors, and some doctors in training confirmed this.

13 Doctors in training told us that the learning environment is supportive and allows them to raise concerns should they feel they are working outside of their competence. Doctors in training in O&G told us consultants are contactable and are willing to provide support when required. Doctors in training in GIM told us they feel comfortable with asking for support to ensure they do not work outside of their competence.

14 Clinical and education supervisors told us of processes that can inform determining a learners' level of competence. They noted that the transfer of information (TOI)

process can provide information in relation to learners' competence, annual review of competence progression (ARCP) can indicate potential issues with competence and also supervisors observe learners performance in practice.

Identifying learners at different stages (R1.10)

15 During the visit, doctors in training and staff at the trust frequently 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) and doctors in the first and second years of core medical 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 when SHO and registrar terminology is used due to the ambiguity of the different level of doctors in training included in the acronym.

Taking consent appropriately (R1.11)

- 16** All doctors in training told us they only take consent for procedures appropriate for their level of competence. Some of the doctors in training that we met noted that consent is covered during their induction and others told us about school specific inductions to consent. We also heard about a centralised consent induction run by the Northern Ireland Medical and Dental Training Agency (NIMDTA) to introduce foundation year two doctors to consent procedures.
- 17** Clinical and educational supervisors told us that consent taking is assessed in the work place based assessments and doctors in training supported this. All doctors in training told us that adequate supervision is provided if required when taking consent.

Rota design (R1.12)

- 18** It's clear that the trust is affected by UK recruitment shortages which are impacting on, and increasing rota gaps and workload in some departments. Such shortages are leading to a heavy reliance on locums in some specialties. The education management team acknowledge that workload in urgent care areas, for example EM, can be at times challenging and noted that every effort is made to mitigate this.
- 19** During our visit we found that rota gaps, learning opportunities and workload vary across sites and specialties, with some doctors in training telling us that gaps in their rotas are impacting on their workload and learning; and others telling us that their rotas balance service delivery and training well.
- 20** Foundation doctors in some medicine posts across the trust told us there are issues with rotas allowing appropriate time for training and supervision as they are not fully staffed. Foundation doctors at AAH also noted examples of completing tasks with

little educational value and told us that there are additional strains to the rotas when leave is taken.

- 21** Doctors in training in EM posts told us current rota visibility is poor as the trust is often trying to fill the rota with locums. Doctors in training noted that receiving their rotas with short notice significantly disrupts their work/life balance and added that this issue has been raised. We were told that clinics and teaching sessions can be a struggle to fit in the EM rota and that workload is high, particularly at the weekend. Nonetheless, doctors in training confirmed that their trainers are dedicated to teaching and endeavour to release doctors in training for teaching when possible. EM clinical and educational supervisors confirmed that rota gaps are a pressure in the system.
- 22** Doctors in training in O&G told us their rotas are compliant with European Working Time Directives, supervision and access to learning opportunities is adequate, they have protected time for learning and that pressure between service and education is reasonable. These findings are supported by NTS data which has highlighted green outliers for workload in O&G consecutively over the past three years. Doctors in training in GIM posts also told us that their workload is manageable and noted that there are no issues with their rotas.

Induction (R1.13)

- 23** The education management team told us that induction is a mandatory requirement for all doctors in training. Those who are either new to the trust, or who have not attended a trust induction for more than one year, are required to attend an induction run in either August or February. Topics include specialty-specific guidance in addition to generic workplace; governance and staff safety training. Doctors in training also have a departmental induction when commencing their rotation.
- 24** Generally we heard positive comments about the trust's induction. Some foundation doctors told us that trust induction adequately prepares them for their role, but noted that there is room for improvement in some departmental inductions. We found that the quality of departmental inductions varies across specialties and sites and some doctors in training felt that some departmental inductions could be enhanced; however cardiology departmental induction at AAH was highlighted for containing concise and relevant information. This is supported by the GMC National Training Survey (NTS) which highlights a green outlier for induction in cardiology across the trust in 2016.
- 25** GIM doctors in training told us that trust induction at AAH was adequate and prepared them for their roles. They added that their departmental induction included a tour of the department and information on who to contact should an issue arise. Doctors in higher training in EM and O&G had mixed views on trust induction and some noted it is more suited to junior staff.

- 26** The education management team told us that induction is also provided for undergraduate attachments. During these inductions the layout, structure and level of supervision is explained. The learning objectives, means of assessment and how to seek help are also highlighted. Medical students confirmed they had an induction on their first day of their placement that gave clear guidance on their role.
- 27** We have therefore highlighted trust induction as an area that is working well. The trust's induction is currently under review and we encourage that developments strengthen the current trust induction and develop departmental inductions in line with the standards in *Promoting Excellence*.

Area working well 2: Trust induction is effective in preparing doctors in training and medical students for their rotation or placement.

Handover (R1.14)

- 28** We found that handover systems vary across specialties, and that handover is largely a transactional experience that is shaped on departmental needs and does not maximise learning opportunities for doctors in training.
- 29** Doctors in training in GIM told us that handover is largely informal and noted that two handovers a day take place; the day to the night team and the night to the day team. They added that the day to night team handover is mostly a sit down meeting which is led by senior doctors in training and there is no consultant presence. The consensus was that handover is informal, lacks educational value, and some felt that it may pose a risk to patient safety as there is the potential to lose outlier patients during handover. We were told that handover at the weekend is poorer than mid-week handover in GIM and that it can be difficult to identify patients to be discharged.
- 30** Some foundation doctors in medicine posts told us that handover occurs daily at a set time and that it is led by senior doctors in training. Supervisors confirmed this and added that a daily structured handover occurs but that it is often transactional and lacks learning opportunities. Some clinical and education supervisors in surgery noted that handover is comparable to a business transaction as opposed to an educational opportunity as there is often a large amount of patients and information to handover.
- 31** However, doctors in training in O&G told us that handover provides continuity of care for patients and is a learning opportunity. Clinical and educational supervisors added that handover occurs three times a day, is consultant led and that it is a learning opportunity as cases are discussed in a multidisciplinary meeting. This is supported by the 2016 NTS results which highlight a green indicator for handover in O&G.
- 32** The education management team told us about the innovation quality improvement project completed by foundation doctors aiming to improve trust handover processes. Some clinical supervisors told us how they felt the implementation of this project has

improved handover efficiency and improvements are likely to be rolled out across the region. Whilst we recognise that attempts have been made to improve handover we have set a requirement for the trust to address in its journey in improving handover systems across sites and specialties.

Requirement 3: Handover must be organised and scheduled to provide continuity of care for patients, ensure patient safety and to maximise the learning opportunities for doctors in training.

- 33** We are concerned about the flow of patients from the EM department to the rest of the hospital at AAH. Doctors in training in GIM told us that the emergency department is focused on hitting the four hour waiting target introduced by the Department of Health. The target stipulates that patients attending emergency departments must be seen, treated, and admitted or discharged in under four hours. During the visit we heard examples of patients being transferred with incomplete management plans and without the initial appropriate tests due to time pressures.
- 34** Doctors training in EM supported that there are significant time pressures to see, admit, transfer or discharge patients and the consensus was that this has become stronger over previous months. We were told that the target has led to doctors in training admitting patients they would not normally admit as a result of feeling pressurised.
- 35** Supervisors in EM were aware of the high workload of the department, but were not aware that doctors in training in EM posts felt pressured to handover patients. and that doctors in training in surrounding wards were noting that patients are being moved with incomplete management plans. We have therefore set a requirement for the trust to address.

Requirement 4: The trust must ensure that time pressures in the emergency department at Antrim Area Hospital do not impact on doctors in training completing appropriate tests for patients, nor subsequently the handover between the emergency department and the rest of the hospital.

Protected time for learning (R1.16)

- 36** We found that most doctors in training, including those in GIM, medicine and foundation posts, do not have protected time for learning opportunities as teaching is not bleep free. AAH has a triple red outlier for local teaching in general surgery and our findings during the course of our visit supported the issues highlighted in the NTS in the specialty. However, we found that regional teaching is generally protected.
- 37** Some foundation doctors at Causeway Hospital told us their teaching is neither protected nor bleep free. We were also told there is no formal scheduled teaching in paediatrics at Causeway Hospital. Most doctors training in O&G across the trust noted they do have protected time for learning.

- 38** However, doctors in higher specialty training in O&G (ST6&7) at AAH told us it is difficult to fit their additional study modules into the rota. Doctors in core surgical training at AAH told us they are released for core surgical teaching organised by NIMDTA.
- 39** Most clinical supervisors acknowledge that teaching time is not protected. Some added they have tried to ensure teaching is bleep free but it was not successful due to the difficulties with balancing teaching and service pressures.
- 40** We note there are discrepancies between specialties having protected time for learning. However, we are concerned that many doctors in training in some specialties may not be able to meet the requirements of their curriculum as they do not have protected time for learning. We have therefore set a requirement for the trust to address.

Requirement 5: Doctors in training must have regular, scheduled and protected time for learning in order to meet their required curriculum outcomes.

Multiprofessional teamwork and learning (R1.17)

- 41** The education management team told us the trust is committed to providing a collaborative learning environment. The trust hosts multiprofessional training courses for obstetric emergencies, as well as the courses that resuscitation officers run for all relevant staff. In addition, we also heard about the morbidity and mortality meetings run in departments across the trust, which are attended by consultants, a range of doctors in training and nurses.
- 42** Medical students confirmed that the trust promotes a culture of multiprofessional collaboration. They have had the opportunity to: spend the day with nursing students and simulated patients; interact with pharmacists; and shadow allied health workers from across the community, including social workers, speech therapists and community nurses.
- 43** Some doctors in training told us about pharmacy awareness sessions, in particular doctors in training in EM noted that they work closely with pharmacists. Some doctors in training also commented on pharmacy and occupational therapist teams, noting that they have an active input into medical teaching. At Causeway Hospital we met the pharmacist who is involved in final year assistantship training (also known as F0). This involves providing training on common issues faced by foundation doctors in order to prepare students for facing them when they enter foundation training. Pharmacists also input into the foundation induction in order to enable foundation doctors to understand the information they will need to provide about discharged patients. Additionally, as mentioned in R1.14 in more detail, we were also told about multidisciplinary handovers in some specialties.

Adequate time and resources for assessment (R1.18)

44 Generally we found that learners and educators are given adequate time to complete assessments as required by the curriculum. Most doctors in training told us they are meeting work place based assessment (WPBA) requirements and that consultants are keen to go through WPBA with doctors in training. Some foundation doctors added that there is adequate time for assessments and they receive good quality feedback. However, some doctors in higher specialty training in EM and O&G told us that finding time to complete assessments required by the curriculum can be difficult.

Capacity, resources and facilities (R1.19)

45 The education management team at the trust told us that both AAH and Causeway Hospital have purpose built educational facilities with sufficient computers and library access. They added that there are computer suites on all three sites with swipe card access, and learners also have extended access to resources including electronic journals. Doctors in training confirmed library access is sufficient and noted it is well utilised. They confirmed they have access to e-journals and internet access is good.

46 Medical students that we met at AAH noted issues with the coordination of their accommodation. They told us internet connectivity in their accommodation when they are on placement at the trust is poor and often disrupts and prevents learning in their own time.

47 We heard from doctors in training that the emergency department has computers on wheels; however, some noted the varying quality of the computers on wheels as well as the difficulties and tensions around locating and using computers.

48 During the visit we identified issues with physical space. We heard that on some wards there is no designated doctors' room and heard about instances of handover of patient information taking place in public spaces due to inadequate capacity. Additionally, we heard the outpatient department is limited in physical space for doctors in training to attend clinics.

49 We are concerned that the lack of physical space is impacting on the ability to discuss patients and complete tasks. Some doctors in training told us that meetings are restricted due to limited space, which subsequently has the potential to impact on working relationships. We also heard about their struggles to find space to complete administrative tasks and we heard examples of doctors in training sitting in the discharge lounge during their breaks. Some supervisors confirmed that doctors in training do not have dedicated physical space in most departments. We have therefore set a requirement for the trust to address.

Requirement 6: The trust must ensure there is adequate physical space to ensure patient confidentiality and deliver safe and relevant learning opportunities for doctors in training.

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

- 50** The trust has recently opened a simulation suite in AAH with a business case for a simulation suite in Causeway Hospital underway. They have recruited a simulation lead and at the time of our visit were in the process of recruiting a simulation lead for both sites. However, in the meantime, resuscitation officers are continuing to run simulation training and drills with multidisciplinary & multiprofessional staff in the emergency department, paediatrics, neo-natal, obstetrics, anaesthetics and intensive care medicine.
- 51** Doctors in training confirmed there is a simulation suite at AAH but that there is no scheduled timetable and sessions are not regular and added that simulation training would benefit from some structure. Supervisors told us they are beginning to use the simulation suite more, particularly in EM and O&G. The education management team acknowledge that simulation at the trust is in its infancy. We encourage the trust to develop the delivery of technology enhanced and simulation based learning in order to enrich training programmes.

Access to educational supervision (R1.21)

- 52** All the doctors in training confirmed that they have an educational supervisor and medical students confirmed they have an academic supervisor. The education management team at the trust told us the clinical sub-dean has oversight of the supervision of medical students and liaises with the named undergraduate leads. Medical students are supervised by undergraduate leads in each specialty. Some medical students told us that their sessions with their academic supervisor often feel focussed on their e-portfolio as opposed to their learning outcomes for placement.
- 53** Doctors in training meet with their educational supervisor when they first arrive on their rotation and then on a regular basis throughout the duration of their rotation. They told us the sessions are useful and they meet formally on average three times a year, but also noted educational supervisors are contactable and accessible informally and when required. Some GIM doctors in training at AAH praised their supervisors and told us they recommend study leave, courses and ensure they are free to undertake procedures.

Supporting improvement (R1.22)

- 54** During the visit we were told about the trust's innovation quality improvement project. This trust wide project aims to involve learners in undertaking activity that drives improvement in education and training to the benefit of the wider health service. The education management team told us about a quality improvement project completed by foundation doctors aiming to improve trust handover processes. Some clinical supervisors told us how they felt the implementation of this project has improved handover efficiency and improvements are likely to be rolled out across Northern Ireland.

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)

- 55** During the visit we identified a disparity between the undergraduate and postgraduate educational governance structures. Whilst undergraduate educational governance has clear, robust structures, we found that postgraduate educational governance lacks formal processes to manage quality issues. Additionally, we also found that educational governance is not adequately discussed at board level.
- 56** The clinical sub-dean (CSD) has oversight of the delivery of the undergraduate education and is accountable to QUB. Undergraduate education is actively monitored through close co-operation with clinicians and senior faculty from QUB, and we heard there are regular meetings between the CSD and trust undergraduate leads to discuss educational matters. However, we were not able to identify the same formal and robust structures for postgraduate education and training, but we were assured that informal quality control of postgraduate education occurs.
- 57** The education management team told us the Director of Medical Education (DME) and the Foundation Programme Director (FPD) report to the Executive Medical Director who sits on the trust board. The education management team acknowledge that historically educational governance is not well sighted by the trust board; some noted the trust board is not supportive with education matters, as service delivery takes precedence. We found that local quality measures exist and heard that the postgraduate dean reports concerns to the Chief Executive. However, information reporting is not formalised at trust board level. During the visit the education management team told us they are taking steps to address the lack of education representation at board level. We encourage the trust to continue to address this in order to demonstrate accountability for educational governance at trust board level, and have therefore set a requirement for the trust to address.

Requirement 7: There must be formal governance structures in place to control the quality of medical education and that educational governance is represented at board level.

Considering impact on learners of policies, systems, processes (R2.3) & Evaluating and reviewing curricula and assessment (R2.4)

- 58** We found that the views of students, doctors in training and educators are taken into account at trust level to improve systems or processes and to evaluate the delivery of the curricula. Some clinical and educational supervisors added they receive written feedback from medical students which allows them to reflect on their current teaching programmes.
- 59** Medical students told us they complete an evaluation at the end of their placement. They added they occasionally receive an email from QUB outlining what has been changed as a result of their feedback.
- 60** The education management team told us that the trust collates feedback from medical students regarding the quality of teaching they have received on their placements, with the aim of identifying good practice and addressing any negative feedback. Feedback is disseminated to all relevant undergraduate leads. Formally the CSD meets quarterly with QUB to discuss issues and provide structured feedback. Feedback is also sent to QUB informally on a regular basis.
- 61** We heard that some departments seek feedback locally from doctors in training. In particular, we were told that feedback from paediatrics is shared with the DME. Clinical and educational supervisors told us they receive feedback from doctors in training in relation to their teaching, which enables them to modify their teaching programmes.
- 62** Additionally, the education management team told us the trust utilises the NTS as a tool to consider the views of learners, and added they scrutinise the results with the aim of improving systems and processes.

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

- 63** The education management team told us the trust has a service level agreement with NIMDTA and QUB, which outlines the level of service expected in order to ensure education and training is effectively managed and standards are met.
- 64** The trust has systems and processes in place to monitor the quality of education and training. Undergraduate education is actively monitored through the review of student feedback and in close co-operation with the CSD, clinicians and senior faculty from QUB. There are regular meetings between the CSD and trust undergraduate leads to support the quality control of undergraduate education. The CSD also attends meetings with senior faculty and there are twice yearly site visits by QUB's senior faculty. Student feedback on attachments is utilised in order to modify and improve teaching programmes. Additionally, the trust submits an annual accountability report to QUB outlining how the trust has met the requirements outlined in the service level agreement.

- 65** In order to monitor and improve the quality of postgraduate education, the trust uses the action plans produced from NIMDTA's scheduled visits and information from the NTS is scrutinised. The delivery of the foundation programme curriculum is monitored by the foundation programme directors (FPDs). FPDs meet regularly with the DME and the associate dean for foundation to discuss education and training.

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

- 66** It is evident that the trust's working relationship with QUB is working well. There are clear and robust structures in place for sharing information with QUB, which are explained in more detail in R2.6.
- 67** The education management team told us the trust's working relationship with NIMDTA is functional. They added they have quarterly meetings with NIMDTA but that there is less contact with NIMDTA in comparison to their contact with QUB. Additionally, the education management team told us the interface with NIMDTA is not as well defined as it is with QUB and there is room for improvement. We heard the relationship with the foundation school works well.

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

- 68** The trust has systems and processes in place which endeavour to make sure learners have appropriate supervision. The education management team told us all doctors in training have a named clinical supervisor for their rotation at the trust. They noted the quality of clinical supervision is closely monitored by specialty clinical leads, clinical directors and divisional medical directors and added that feedback from the NTS regarding clinical supervision is scrutinised and actioned.

Managing concerns about a learner (R2.16)

- 69** In terms of identifying and managing concerns about a learner, the TOI process (which is detailed further in R2.17) is the formal process to assist with the identification and management of doctors in training requiring support. Once issues are identified referral to occupational health services is crucial in supporting learners' wellbeing. For undergraduate there is close co-operation between QUB and the CSD when known difficulties or new concerns become apparent.

Sharing information of learners between organisations (R2.17)

- 70** The education management team told us they utilise NIMDTA's TOI process in order to share information about doctors in training when concerns about safety, wellbeing or fitness to practise have been identified. TOI also takes place between QUB and the trust, as well as the foundation and specialty schools and the trust. Concerns arising regarding a student on an undergraduate placement are fed back to QUB through the CSD. Formal TOI occurs from QUB to NIMDTA when students progress to the foundation programme, and this is disseminated to the relevant DME or FPD.

- 71** We heard that previously TOI occurred bi-annually between relevant organisations. However, this system has now moved to a live reporting system, in which NIMDTA sends information to the medical director's office at the trust for dissemination.
- 72** During the visit we found that processes are not utilised as well as they should be. We heard that the TOI system doesn't work as outlined in the process and heard examples which reinforced there are inadequate thresholds for transferring some information. Some clinical and educational supervisors told us TOI forms are completed with the doctor in training present, and added this can make it difficult to write an accurate account of concerns. We found a culture of informality around transferring information, with supervisors noting that TOI occurs through word of mouth. In addition, we heard examples of doctors in training arriving to rotations and supervisors not being aware of ongoing concerns.

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

- 73** The education management team told us that educators undergo a recruitment and selection process overseen by the trust's HR department. They added the trust has a recruitment and selection policy which is adhered to during the recruitment process.

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)

- 74** The education management team told us the trust has a policy on equality and diversity, which is part of trust mandatory training and actively monitored through HR procedures. Online learning is part of the e-learning induction package and progress is monitored and fed back to the postgraduate education office for action where necessary.
- 75** However, during the visit we found that universally there is a lack of understanding around the key principles of equality and diversity in both learners and educators. In addition, we found that equality and diversity training is not consistently monitored within the trust and many are not up-to-date with their training.
- 76** We found discrepancies in understanding around equality and diversity training. Whilst some doctors in training told us they complete online modules on equality and diversity, others were not clear if they had completed training, and some said they have done no training at all. Those that told us they complete online modules added they should be completed in the first month and they receive email reminders if online modules are not completed. Once online courses are completed a certificate should be sent to HR as proof. However, many were not aware of this process and we remain concerned that the trust is not adequately delivering and monitoring equality and diversity training. We have therefore set a requirement for the trust to address.

Requirement 8: Learning outcomes from equality and diversity training must be clearly understood and applied in practice, such that learners are able to demonstrate they meet the professional standards required of them. Equality and diversity training must be appropriately monitored, and learners and educators must be up-to-date with their training.

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

- 77** The trust has a health and wellbeing strategy which outlines their approach and framework to enhancing the health and wellbeing of its staff. The education management team told us learners have adequate access to resources to support their health and wellbeing and that pastoral support is readily available from all members of the education team. In undergraduate education when concerns become apparent or there are known concerns, there is close co-operation between QUB and the CSD, and subsequently advice is given through QUB student support services.

There is a similar co-operation between NIMDTA and the trust when concerns arise with foundation doctors or doctors in training. Additionally, learners have access to occupational health services.

- 78** Doctors in training told us their clinical and educational supervisors provide some pastoral support and added they are supported by NIMTDA. Some doctors in training noted they would raise their personal concerns directly with NIMDTA in the first instance as opposed to raising them with the trust. Some clinical and educational supervisors told us that if a doctor is in difficulty they will inform NIMDTA about their concerns. Additionally, supervisors told us NIMDTA provides a training support group for doctors in difficulty.
- 79** Medical students told us they receive careers guidance at QUB, including how to strengthen their CV, but noted that a lot of careers advice is given informally. Some doctors in training told us there is adequate careers advice and support available at the trust.
- 80** In particular, foundation doctors praised how well they are supported in relation to their health and wellbeing and noted the foundation programme director (FPD) plays a key role in this and is supportive and accessible. They added they receive regular correspondence from the FPD outlining support available pertaining to health and wellbeing and their e-portfolio. We have therefore highlighted this area as an area that is working well.

Area working well 3: We found the foundation programme director to be supportive and accessible.

Undermining and bullying (R3.3)

- 81** During the visit we heard examples of past undermining and bullying behaviours which the trust has addressed in conjunction with NIMDTA. Some doctors in training told us that undermining and bullying behaviours are department and site specific. However, medical students and many of the doctors in training that we met told us they have not experienced or witnessed undermining and bullying behaviours.
- 82** Some supervisors told us there is an informal culture in the trust whereby doctors in training are reluctant to raise concerns about undermining and bullying behaviours. They added that supervisors can often see issues that are occurring but doctors in training either won't raise concerns or won't take a concern further once it has been raised.
- 83** Some of the doctors in training that we met with at Causeway Hospital told us only the higher grade doctors in training can seek clinical advice from the microbiologist. This means that the lower grade doctors in training are required to contact the consultant or a higher grade doctor in training to ask them to speak with the microbiologist on their behalf. Some doctors in training felt that this creates an

environment that is not supportive for learners; it's not an effective use of time and has the potential to hinder the provision of timely patient care as there are unnecessary barriers to seeking support. We have therefore set this as a requirement for the trust to address.

Requirement 9: The trust must ensure that all doctors in training are able to seek advice from a microbiologist.

84 In addition, we also found that there are consultants in general surgery displaying unprofessional behaviour in AAH. We heard that some senior members of the surgical team deny training opportunities to some doctors in training based on their gender. We also identified that female doctors in training felt their opinion didn't matter and were made to feel inferior if they asked questions during ward rounds. Some clinical and educational supervisors were aware that gender discrimination was occurring.

85 Following the visit, this issue was escalated to the GMC's serious concerns process and NIMDTA was asked to respond to the concern to identify any further relevant information, or if any actions have already been taken or are planned. After we receive a written response from NIMDTA, we will continue to monitor the trust's progress through the below requirement.

Requirement 10: The trust must ensure that education and training is fair, based on the principles of equality and diversity and that doctors in training are not denied training opportunities based on their gender.

*Information on reasonable adjustments (R3.4)**

86 The trust has an adequate reasonable adjustment policy which outlines guidelines for managers when faced with working with those that require a reasonable adjustment to be implemented. During the visit we heard examples of reasonable adjustments that have been implemented for learners. Doctors in training do not perceive there to be any barriers to accessing reasonable adjustments and told us they would request a reasonable adjustment through their educational supervisor. However, they were not sure of the direct channels to follow if they were to have a request. We encourage the trust to ensure that all doctors in training are aware of how to access reasonable adjustment information.

* The Equality Act 2010 does not apply to Northern Ireland. The Equality Act 2010 is in force in the rest of the UK, but the Disability Discrimination Act 1995 and the Special Educational Needs and Disability (NI) Order 2005 remain in force in Northern Ireland.

Student assistantships and shadowing (R3.6)

- 87** The education management team told us that the trust hosts a mini foundation programme for the final year student assistantship, which is more challenging than shadowing. They added it is team-based, with rotations through medicine and surgery. Learners experience out of hours environments through shadowing F1s on call.
- 88** Foundation doctors told us they had undergone the assistantship programme at AAH before coming to the trust. They added that it's valuable, a good opportunity to meet colleagues, and aided with familiarising themselves with the working environment.

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

- 89** The education management team at the trust told us that they use NIMDTA's policy on less than full time training (LTFT) but added that decisions to grant LTFT training are made within NIMDTA. We met few LTFT doctors in training during the visit, but most doctors in training told us they are not aware of any issues with others obtaining LTFT training.

Study leave (R3.12)

- 90** The education management team told us they endeavour to ensure that study leave is approved and supported when requested and appropriate to doctors' in training curriculum or training programme. Doctors in training are entitled to 30 days study leave per year and certain training courses are taken out of this allocation. Foundation year one doctors are not entitled to study leave.
- 91** Several doctors in training told us they are able to access study leave and some added their educational supervisors recommend study leave courses. However, some foundation year two doctors noted that study leave requests take preference over annual leave requests in some departments.

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

- 92** Medical students told us they are receiving regular constructive feedback on their performance when on placement at the trust. They told us some feedback is verbal and informal, and some added that placements in O&G have a log book with three case based discussions which they receive feedback on.
- 93** Some foundation doctors told us the FPD goes through their portfolio and provides feedback for their development. Some doctors in training confirmed they also receive feedback on their progress.

Career support and advice (R3.16)

- 94** The education management team told us that medical students who are unable to complete their medical qualification are referred to QUB for advice on alternative careers. Doctors in training are referred to the associate dean for career progression at NIMDTA to discuss their career opportunities.

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)

- 95** The education management team told us clinical supervisors are recruited and selected from a pool of interested clinicians who have completed the required courses and are approved by NIMDTA. Educational supervisors are recruited and selected by NIMDTA. NIMDTA runs several development training programmes a year and the trust releases supervisors to attend these courses.
- 96** Educators receive yearly appraisals that include education and training. However, there is no separate educational appraisal; training needs for trainers are identified and discussed as part of the personal development plan which is developed during trust appraisal. Educators confirmed they receive a yearly paper based appraisal and some added the trust is a supportive place to teach.

Time in job plans (R4.2)

- 97** Nearly all of the educators that we met told us they do not have adequate time in their job plans to meet their educational responsibilities. However, the DME's job plan specifies educational activity along with the foundation directors and foundation educators. The education management team told us for postgraduate education there is no formal job plan allocation. The recognition of postgraduate education roles in job planning, with additional external funding, is being developed across Northern Ireland. The trust is currently reviewing its job planning process, and it is anticipated that when the Northern Ireland-wide process has been introduced, there will be formal recognition of educational and training activity in job plans.
- 98** The educators that we met acknowledge the ongoing work streams around ensuring they have adequate time in their job plans. We encourage the trust to continue with their work in this area to ensure that all educators have adequate time in their job plans.

Recognition of approval of educators (R4.6)

- 99** The education management team told us that all trainers have been developed and supported to become recognised and approved trainers. The DME holds a database of accredited trainers which details all the courses educators have completed.

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)

100 The clinical sub dean has oversight of the delivery of undergraduate curriculum at the trust and several undergraduate leads at the trust are involved in the day to day delivery of undergraduate education.

101 Medical students confirmed they have sufficient practical experience to achieve their learning outcomes while on placement at the trust. The education management team told us undergraduate teaching is provided in a range of formats in order to ensure students achieve their learning outcomes. These include: tutorials, ward based learning, ward round learning and simulation learning.

102 Medical students told us they receive ample information in advance of their placement and education management added that timetables for undergraduate clinical attachments are prepared locally and developed in conjunction with staff at QUB. The timetable is developed based on the undergraduate curriculum. Medical students on surgery placements told us the placement is well organised and they have an induction on their first day which makes them aware of who to contact if they have any issues. They added that they are made to feel part of the team upon their arrival.

Training programme delivery (R5.9)

103 Throughout our visit we heard that the O&G department at both sites is working well. Doctors training in O&G posts are generally content in their roles. We found they are well supervised, have adequate access to educational opportunities and have a reasonable workload. Some told us their working environment is supportive and departmental reporting systems are functional. This is supported by the 2016 NTS results which identified several green outliers at trust level when split by post specialty, including a triple green outlier for workload. We have therefore identified this as an area working well.

Area working well 4: Obstetrics and gynaecology is working well across the trust. The units are functioning well and doctors in training are content in their roles.

104 We also found that clinical exposure for doctors in higher training is good. Work undertaken by higher doctors in training at the trust is giving an appropriate breadth

of clinical experience. Some higher doctors in training told us they are content with the experience they are getting at the trust and there are some good training opportunities. They added that the case mix largely enables them to meet the requirements of their curriculum, and supervisors in EM in particular highlighted the varied case mix in the department. We have therefore identified this as an area that is working well.

Area working well 5: Doctors in higher training are obtaining sufficient practical experience to achieve the clinical competencies required by their curricula.

105 However, despite identifying that clinical exposure for higher doctors in training is an area that is working well in the trust; we found that at times education is compromised for foundation doctors as they often carry out routine tasks with little educational value. Some foundation doctors in some specialties at AAH told us that at times they are not able to attend clinics or theatre due to workload. Some added they only complete ward based care as their roles are too busy to leave the ward. They noted that at times this can leave them feeling undervalued and over worked. In addition, some medical students commented that foundation doctors are completing mundane tasks and do not appear to have adequate learning opportunities.

Requirement 11: Foundation doctors must receive sufficient and relevant practical experience and training to achieve and maintain the competencies required by their curriculum.

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