

## Visit Report on Nottingham University Hospitals NHS Trust

This visit is part of the East Midlands regional review.

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

### Summary

<b>Education provider</b>	Nottingham University Hospitals NHS Trust
<b>Sites visited</b>	Queens Medical Centre
<b>Programmes</b>	Foundation, core medical training, gastroenterology, emergency medicine, acute internal medicine, general internal medicine, cardiology and anaesthetics.
<b>Date of visit</b>	20 October 2016
<b>Overview</b>	<p>Nottingham University Hospitals NHS Trust is the main and largest teaching hospital for the University of Nottingham School of Medicine. It is also the fourth largest acute trust in England and provides services to more than 2.5 million residents of Nottingham and the surrounding communities. The Trust operates through three sites: Queen's Medical Centre, Nottingham City Hospital and Ropewalk House.</p> <p>The latest Care Quality Commission report (September 2015) gave an overall rating of 'good' to the trust whilst stated that services required improvements in terms of safety. At the time of our visit, the trust was due to go through a merger with Sherwood Forest Hospitals NHS Foundation Trust. We heard after the visit had taken place</p>

that the merger had been cancelled and the two trusts will continue to operate as two separate entities\*.

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

## Areas that are working well

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

Number	Theme	Areas that are working well
1	Theme two (R2.2)	<p>The reforms undertaken by the new education team are positive and should be supported to improve accountability for educational governance in the trust.</p> <p><a href="#">See paragraphs 33 &amp; 34</a></p>
2	Theme three (R3.1)	<p>The doctors in training in the different specialties said they are well supported within their specialty training. They appreciate the breadth of training and learning opportunities in the trust.</p> <p><a href="#">See paragraph 44</a></p>
3	Theme three R5.4	<p>The students we met were complimentary of the environment at the trust, feel well supported and are particularly enjoying working with the teaching fellows.</p> <p><a href="#">See paragraphs 64 &amp; 65</a></p>

## Requirements

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

Number	Theme	Requirements
1	Theme one (R1.12, R1.16)	<p>The trust must look into the working patterns and levels of workload for doctors in training.</p> <p><a href="#">See paragraphs 13-16</a></p>

2	Theme one (R1.13)	The trust must ensure that all doctors in training receive an appropriate induction before undertaking on-call duties. This includes a departmental induction at each rotation for doctors in the foundation programme.  <a href="#">See paragraph 19</a>
3	Theme one (R1.14)	The trust must investigate the communication surrounding the process of tagging and transferring patients from the emergency ward to other hospital departments.  <a href="#">See paragraph 23</a>
4	Theme three (R3.3, R3.5)	The trust must investigate and address the bullying and undermining concerns raised by foundation year one doctors.  <a href="#">See paragraph 50</a>

## Recommendations

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

Number	Theme	Recommendations
1	Theme one (R1.7, R1.8)	The trust should clarify and ensure that rotas for gastroenterology provide the appropriate level of supervision.  <a href="#">See paragraph 10</a>

## Findings

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

### Theme 1: Learning environment and culture

Standards
<p><b>S1.1</b> <i>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.</i></p>
<p><b>S1.2</b> <i>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.</i></p>

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

- 1** Before the visit the trust told us that doctors in training are made aware during induction of processes to raise concerns and report incidents. The trust also said that there is an open culture about raising concerns. This is also supported by the national trainee survey (NTS) results. In the 2016 survey the vast majority of doctors in training reported that they are made aware of how to report patient safety incidents and near misses and there is a culture of proactively reporting concerns in the trust. During our visit we also heard from the doctors in training we met that they are encouraged and supported in raising concerns. Doctors in training were able to provide examples of the support they received from consultants and members of the multidisciplinary team when reporting incidents.
- 2** In the 2016 NTS the majority of doctors in training responded that they are confident that concerns are dealt with effectively and there is a culture of learning from concerns raised or near misses. Doctors in core medical training we met during the visit reported that in the emergency department an email is sent around with all the near miss cases and lessons learnt. All cases are anonymised. Doctors in higher training in general internal medicine and gastroenterology mentioned that they have monthly mortality and morbidity meetings where they discuss near miss cases and lessons learnt which they find useful. The students from University of Nottingham School of Medicine that we met also said that they know how to raise concerns about patient safety and feel confident to do so.

### *Supporting duty of candour (R1.4)*

- 3** The trust has a *Being Open (Duty of Candour) Policy* which they share with doctors in training during their induction. They also have a 3 minute podcast available on the intranet and internet. The doctors in training we met during the visit confirmed that they are aware of the duty of candour and they feel comfortable with being open about their mistakes with patients and colleagues.

### *Seeking and responding to feedback (R1.5)*

- 4** In the meeting with the education management team we heard that the version of DATIX the trust is using enables them to identify doctors in training if the trainee chooses to fill in their training grade when reporting the concern. Whenever it is identified that a doctor in training had been involved in a concern raised on DATIX, they aim to give them face-to-face feedback
- 5** However, the doctors in training we met said that, although they receive an acknowledgement email when they report an incident on DATIX, they do not get any feedback afterwards about how the case was dealt with. This might be because the doctors in training are not filling in the field in the form specifying their level in which case the trust should provide some further training in using DATIX and explain the importance of fully completing the report.

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

- 6** The doctors in training we met during the visit are aware of the local processes for educational and clinical governance. Doctors in core medical training said that they are engaged with the junior doctors' forum and they get regular emails and updates from their representative to the forum. They also said that they have a college tutor who ensures that they are meeting the number of clinics required in their curriculum.
- 7** All groups of doctors in training we met reported a good level of engagement with their educational supervisors. The doctors in training said they have regular meetings and they would report any issues regarding their training to the educational supervisors. The foundation doctors were aware of who the training programme director was for the foundation programme and said that their e-portfolio includes a list of useful contacts.

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

- 8** The trust considers that they have sound mechanisms to ensure a safe environment and the right level of supervision for doctors in training. All doctors in training are allocated a clinical supervisor prior to starting their attachment at the trust and the trust end of attachment surveys indicate that the majority of doctors in training feel

that they have the right level of supervision during their time at Nottingham University Hospitals Trust.

- 9 During the visit we asked the different groups of doctors in training about clinical supervision. The majority of them recognised the challenges of a busy environment and sometimes understaffed teams. Despite this most reported a good level of clinical supervision. Doctors in training at different stages of training commended the support and availability of consultants and told us that they don't work unsupervised.
- 10 However, during the visit we heard from doctors in higher training in gastroenterology that they have very little clinical supervision and are working mostly on their own without senior support. This group of doctors in training said they are managing the majority of referrals themselves and often felt unable to deal with all tasks due to shortage of time. We were unable to triangulate this finding fully during our visit and the clinical and educational supervisors in gastroenterology denied that any group of doctors in training are working without adequate clinical supervision. Therefore we have asked the trust management to investigate this issue further.

**Recommendation 1:** The trust should clarify and ensure that rotas for gastroenterology provide the appropriate level of supervision.

*Taking consent appropriately (R1.11)*

- 11 The doctors in training we met during the visit said that they are aware of the guidance on consent and the trust has provided them with training on this at induction or during their placement.

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

- 12 The CQC visit in September 2015 identified rota gaps at the trust, but recognised that vacancies were generally managed well. The trust told us that they recognise the fact that they have a number of vacancies on a few rotas. They have taken steps to recruit doctors outside training programmes (trust grade doctors) to help with rota gaps and, in return, are supporting these doctors into entering training positions within the region. They also said that rotas are monitored through an electronic task management to ensure that doctors in training do not work beyond their competence or without appropriate supervision.
- 13 The doctors in training we met during our visit commented on the impact that rota gaps are having on their workload. F1 doctors told us that their rotas are compliant on paper with the European Working Time Regulations (EWTR). However, doctors in training are working beyond contracted hours and working time regulations and have no scheduled breaks in their rota. Foundation year two (F2) doctors and those in core medical training said that their rotas do not make up for a balanced workload and do not allow them time to attend mandatory training. They said that they had to

attend clinics or teaching sessions when they are off work and take exam days as personal holiday rather than study leave.

- 14 The situation seems to be slightly better for doctors in higher training, who said the trust has made some improvements recently with filling in rota gaps. However they too reported that rota gaps are affecting their workload.
- 15 The doctors in training we met were positive about the quality of local and regional teaching sessions. Doctors in core medical training praised the quality of local teaching in acute internal medicine, general practice and cardiology departments. The same group of doctors also said that regional teaching has improved from previous years.
- 16 The main issue for almost all doctors in training we met is that rotas are inflexible and do not allow for protected time for them to attend training and teaching sessions. This was a widespread problem across levels of training and departments. Doctors in training try to swap shifts between themselves to attend training. However this is not always possible.

**Requirement 1:** The trust must look into the working patterns and levels of workload for doctors in training.

- 17 We heard from doctors in higher training that supervision in gastroenterology is patchy and at times doctors in training are working without adequate supervision. We also heard from educational and clinical supervisors in gastroenterology that this is not the case.

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

- 18 Prior to the visit we learned from the trust that improvements were made to induction following feedback from learners. The trust now organises a central induction four times a year and this includes aspects of mandatory training and trust policies. In addition doctors in training attend a departmental induction which is tailored to different specialties. To enable familiarisation with trust guidelines and policies, the trust has developed a guidelines app which trainees can access through an iPhone.
- 19 During our visit we heard from doctors in training that they feel the trust induction is something of a tick box exercise. They complete the e-induction in their own time and get time in lieu for it. Foundation doctors said that the e-package of induction did not have all the information they would like to know about the trust. They also said that sometimes they had started in a late shift without having a departmental induction first. Doctors in different levels of training said that the departmental inductions also need improving because they lack a practical introduction to the work that was expected of doctors in training in their respective departments. We were told that most of the departmental inductions take place at the same time and

doctors in foundation programme and core medical training who work in more than one department cannot attend all the sessions relevant for them.

**Requirement 2:** The trust must ensure that all doctors in training receive an appropriate induction before undertaking on-call duties. This includes a departmental induction at each rotation for doctors in the foundation programme.

#### *Handover (R1.14)*

- 20 The trust told us before the visit that handover between teams is done through electronic devices and accompanying software. The trust said they have in place an electronic task management system called 'e-Observations and e-Handover' which "*enables electronic observations with real time alerts and automatic escalations to relevant personnel, including senior staff*". The electronic system also incorporates task management and enables teams to allocate tasks to doctors in accordance with their level of training.
- 21 The doctors in various levels of training we met described sound systems for handover within different departments. We heard that handover takes place formally at regular times between teams for anaesthetics, acute medical specialties and emergency medicine departments. The doctors in training we met said that handover within their departments allows for learning opportunity and consultants do pay special attention to their learning needs. The responses in the 2016 NTS survey were also positive regarding handover.
- 22 Doctors in training are aware of the electronic system for handover described above (the 'nerve centre'), however they described it more as a task management system rather than an electronic handover platform. Doctors in training in different levels said that the system has the potential of becoming a robust mechanism for handover, however, currently; it does not have all the necessary information to replace face-to-face handovers.
- 23 The trust must investigate the communication surrounding the process of tagging and transferring patients from the emergency ward to other hospital departments.

**Requirement 3:** The trust must investigate the communication surrounding the process of tagging and transferring patients from the emergency department to other hospital departments.

#### *Adequate time and resources for assessment (R1.18)*

- 24 We were unable to gather extensive information on work based assessments during our visit. However, we did hear from F1 doctors that they do complete their work based assessments and consultants are available to observe and sign off their assessments. The clinical and educational supervisors we met during the visit

confirmed that although they manage heavy workloads they do find time to supervise and support doctors in training in completing their work based assessments.

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

**25** The trust told us that they have built two education centres, one at Queen's Medical Centre and one at City Hospital. There are also clinical skills centres at both sites and one simulation centre based at Queen's Medical Centre. The medical students we met during our visit praised the facilities and particularly the library resources at the trust. The doctors in training we met did not particularly comment on the facilities, but they were generally happy with their training experience at the trust.

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

**26** The medical students we met spoke highly of the simulation-based teaching they receive at the trust.

*Access to educational supervision (R1.21)*

**27** The trust education management team said during the visit that they make sure all doctors in training have access to educational supervision. They also ensure that foundation doctors meet with their educational supervisors at the start and end of each training block as required in the ARCP. For doctors in core medical training the requirement is a minimum of two meetings per year and the trust are ensuring that this take place. The trust told us that all consultants who take up educational supervision roles are trained and have the necessary time accounted in their job plans. The doctors in training we met during our visit confirmed that they have a named educational supervisor and they meet regularly.

## 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)*

- 28** The trust has in place a number of committees to support educational governance, however it is not clear from the flowchart we were shown how different structures link together to manage the quality of education and training provided at the trust. The postgraduate director of medical education (DME) is responsible for the provision of postgraduate medical education, and reports to and meets regularly with the medical director (MD) who has responsibility for education matters at Board level.
- 29** We were told during the visit by the senior management team that the Learning and Education Committee (LEC) has responsibility for the overall quality of education and training. The organisational committee chart suggests that the DME and his team have an influencing role on the Education and Conference Centre which in turns has an informal reporting link to LEC. We could not determine a clear line of reporting between the different structures.
- 30** The trust has a junior doctors' forum which has undergone a recent review and restructuring to enable better engagement of doctors in training into quality management and control systems. The junior doctors' forum (JDF) is now comprised of sub-forums which have improved engagement with doctors in training and provided a platform for their views to be collected. From the documentation submitted by the trust we could not clearly determine how the views of doctors in training were represented in the quality management structures.
- 31** The senior management team told us during the visit that they have numerous surveys to monitor the quality of education and training provided at the trust. They recognised the need for the trust to improve on the local collection of data and compare them to the NTS results, as well as engage more with trainers and tutors. The trust has plans to re-introduce in 2017 a postgraduate and undergraduate committee where educational supervisors and tutors will be represented.

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

- 32** The MD is responsible for discussing education and training matters at Board level. However, we could not find any education issues being mentioned in several Board meetings minutes and could not conclude whether the Board has taken an overall responsibility for the provision of education and training at the trust. During the visit we attempted to explore the mechanisms by which education matters were taken to the Board, but could not determine a clear line of accountability.
- 33** The senior management team told us that currently there are several reports on education and training which are taken to the Board, but there is no overarching education report being presented. The trust has recently undergone staff changes in the education management and the new team plans to strengthen the reporting lines from the LEC to Board and introduce a comprehensive education report to be available to the trust Board regularly.
- 34** The education management team has undertaken some positive initiatives which can improve the accountability for educational governance within the trust. Such initiatives include providing support for doctors in training through changes in the junior doctors' forum, the appointment of junior doctors' liaison officer and their prompt action to address rota gaps.

**Area working well 1:** The reforms undertaken by the new education team are positive and should be supported to improve accountability for educational governance in the trust.

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

- 35** The senior management team said during the visit that they regularly look at the progression data for their doctors in training and compare the information with the national records. They said they have developed matrices which clearly show where they stand in terms of collection of Equality and Diversity (E&D); for example the trust are aware that they have a parity of white and BME ethnicities in the medical workforce, but this is not reflected at medical management level. The trust has plans to improve its analysis in the future and look at progression data with regards to ethnicity.

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

- 36** The majority of doctors in training told us during the visit that they raise any concerns about their education and training through their educational supervisors. Doctors in core medical training also mentioned that they have a dedicated forum which is overseen by the college tutor. They are able to raise concerns about their training in this forum and are aware that their issues are also discussed in the JDF. This group of doctors said that they also receive feedback from their JDF representatives and welcome the appointment of the junior doctors' liaison officer.

- 37** Doctors in higher levels of training said that they do fill in end of placement surveys, but they are unsure how this feeds into quality management processes and they do not receive any feedback.

*Sharing and reporting information about quality of education and training (R2.8); Sharing information of learners between organisations (R2.17)*

- 38** The senior management team said that they have a very close working relationship with Health Education England working across the East Midlands (HEE EM). The two organisations meet quarterly and these meetings are a good forum to report information on the quality management and quality control of education and training. The trust management are pleased with the information provided by HEE EM on their planned quality visits.
- 39** One issue where the trust would like to see an improvement is the timing of information on doctors in training rotations and the potential gaps. There is an agreement with HEE EM which states that the trust will have a 12 weeks' notice on these gaps. We were told by the trust management that they have a much shorter notice which impacts on their ability to complete workforce planning and rotas. The education management team said that they would also like to see more sharing of progression and attendance data with HEE EM. The education team are aware that the specialty schools collect attendance data and share these with HEE EM, but the trust has no access to this information. The same concern was expressed about ARCP data.
- 40** The education management team said that there are good communications surrounding the movement of doctors in training from one level of training to another. The trust receives formal transfer of information (TOI) forms for foundation doctors or for those moving from core medical training to ST3.
- 41** During the visit we heard that there is good level of engagement on a senior management level with University of Nottingham School of Medicine. However, the trust management team told us that they would like to see a closer working relationship with lower levels of management as well. There is a gap in engagement on educational supervisor and undergraduate tutor level. Until very recently, the trust had little information on the available Undergraduate Tariff funds that were available to them. There has been a recent review of these funds which has empowered the trust to understand the resources available better and to allocate them more efficiently to different departments and divisions in accordance with the level of responsibility these units have for undergraduate education.
- 42** One particular issue with information sharing with the medical school is that of TOI about students. There is no current formalised agreement between the medical school and LEPs providing placements on TOI about students and this has impacted on the trust's ability to provide support. This matter is discussed below under R3.2.

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

- 43** The trust education management team said that they have good support mechanisms for sharing information about learners in difficulty. They hold regular meetings with the foundation or specialty tutors where concerns about learners are discussed. All learners in the trust have access to the Professional Support Unit based at HEE EM and there are good communications established around the referral processes.

### 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)*

**44** All doctors in training and medical students we met during our visit said that they felt supported in meeting professional standards and raising concerns within the trust. They reported an open culture and felt confident in raising issues with their educational and clinical supervisors.

**Area working well 2:** The doctors in training in the different specialties said they are well supported within their specialty training. They appreciate the breadth of training and learning opportunities in the trust.

#### *Learner's health and wellbeing; educational and pastoral support (R3.2); Information on reasonable adjustments (R3.4)*

**45** We found that doctors in training have adequate access to resources to support their health and wellbeing. Doctors in training told us during a presentation that the trust has now appointed a liaison officer who has improved engagement with doctors in training and also provides them with pastoral support. Doctors in training are able, through referral, to have access to the Professional Support Unit at HEE EM and the training support service in the Trust is a good mechanism to support doctors in training. The doctors in training we met did not report any issues with pastoral and wellbeing support.

**46** The trust education management team said during the visit that for foundation level, doctors in difficulty are discussed in regular meetings and there is also a dedicated committee at HEE EM which deals with doctors in training who have had professional issues; we heard about the work of the Serious Concerns Review Group during our visit at HEE EM. There are also formalised channels of communication regarding TOI for doctors in training. The education management team also told us that they have a system for monitoring doctors in training absences and that this information is passed on from one rotation to another. The trust then analyses the data and, if there are any identifiable patterns, they put in place the necessary support mechanism for the doctor in training.

**47** Medical students said that they receive their pastoral support mainly from the medical school. They said that they know where to find information on the available support for their welfare on the medical school website. The trust senior management team told us that the current processes for TOI with the University of Nottingham School of

Medicine can hinder their ability to provide adequate pastoral support for students. This view was supported by the undergraduate trainers we met who also said that not having any information about students prior to the start of the placement makes it difficult supporting them well educationally or pastorally. The same issue extends to being able to provide reasonable adjustments for medical students.

- 48** We were unable to collect sufficient information about careers advice provided to doctors in training to comment on the adequacy, but the F2 doctors we met said that there was a careers guidance course offered, although most of them had been unable to attend.

*Undermining and bullying (R3.3); Supporting transition (R3.5)*

- 49** We asked all groups of doctors in training we met about instances of bullying and undermining in the trust. The overwhelming majority of those we met said that there were no such issues to report. Consultants, trainers and managers are supportive of doctors in training.
- 50** However, during the visit we did hear from F1 doctors of some examples when they felt undermined and unsupported by consultants or doctors in higher levels of training. Examples were given from various specialties and departments and included experiencing generally dismissive behaviours, being shouted at for not clerking patients, and feeling undermined for asking too many questions. We could not triangulate these instances with other evidence during our visit or with the submitted documentation.

**Requirement 4:** The trust must investigate and address the bullying and undermining concerns raised by F1 doctors.

*Student assistantships and shadowing (R3.6)*

- 51** The F1 doctors we met during our visit expressed mixed reviews on the student assistantship. Some of them felt they had a relatively good experience whilst others said they did not feel the assistantship provided a good experience for learning.

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

- 52** The doctors in core medical training told us during the visit that they receive feedback on their performance through eportfolios as well as instant feedback from consultants after interacting with a patient. Doctors in training in anaesthetics spoke of an apprenticeship scheme whereby they received feedback about their performance by a more senior doctor with whom they were working. Doctors in training in medicine specialties said that service demands sometimes affect the time available for feedback.

**53** F1 doctors said they receive feedback through their educational supervisors upon the completion of each block. They also get feedback on each work based assessment by the consultant who observes them. Medical students spoke of varied feedback between placements and different specialties.

## 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)*

- 54** Before the visit the trust told us that they were developing a trainer database and moving towards an electronic appraisal system which specifies the educational roles and responsibilities. When we met with the trust senior management team during the visit we heard that the database is now operational and has enabled them to identify and support educators better. In the same meeting we also heard that the electronic appraisal system is now in place.
- 55** The education management team told us during the visit that all educational supervisors have completed the training provided by HEE EM. The training comprises of face-to-face courses and MedWise, which is an online course run by University of Nottingham School of Medicine in cooperation with HEE EM. Recruitment rounds for new educational supervisors take place every time there are new consultant appointments made to the trust. All trainers are regularly appraised.

#### *Time in job plans (R4.2)*

- 56** The trust has a job planning policy which we saw before the visit. According to this policy consultants are allocated 2.5 SPAs which breaks down into 1.5 SPAs for job planning, appraisal and revalidation attendance, 0.5 SPA for teaching and 0.5 general SPA to deal with the specific needs of the division or specialty.
- 57** The above was confirmed by the trainers we met during our visit who said that they receive a standard 0.25 SPAs for their clinical and educational supervision duties regardless of the number of doctors in training they supervise. However, the trainers we met expressed concerns that the time allocated for educational duties is not balanced and they often had to do e-portfolio work in their own time. We heard of an example where a trainer in emergency medicine was providing educational supervision for seven doctors in training, but had only the standard 0.5 SPA for teaching allocated to look after them all. The allocation of SPAs in the region is addressed in the HEE EM report.

#### *Accessible resources for educators (R4.3)*

- 58** During the visit, the senior management team told us that the recent Undergraduate Tariff review has enabled the trust to allocate the funding to each department based

on their specific needs. This translates into undergraduate tutors and educational supervisors being adequately supported and remunerated for the time spent on undergraduate educational roles.

- 59** The trust told us that they have now introduced departmental agreements for undergraduate medical education and, during the meeting with the education management team, we heard that these agreements have raised awareness of available funding at departmental level and have contributed to an efficient distribution and use of the undergraduate tariff within the department. We were told that the trust would like to mirror the same type of review for the postgraduate funding so they can distribute resources more equitably.

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

- 60** The trainers we met during our visit were aware of the channels available to support doctors in difficulty. They also said that they feel supported to deal with difficulties they encounter as educational supervisors and there are able to cooperate and ask for support from each other within the trust.

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

- 61** The education management team told us that the new database of trainers is useful in recognising, approving and monitoring compliance of trainers in the trust. We heard that all educational and clinical supervisors are being recognised and trained in accordance with the GMC requirements.

## Theme 5: Developing and implementing curricula and assessments

### Standard

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

**S5.2** *Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.*

### *Informing curricular development (R5.2); Undergraduate curricular design (R5.3)*

**62** The trust is the main teaching site for the University of Nottingham School of Medicine and prior to the visit the trust told us that consultants and clinical teaching fellows based at NUH are actively involved as examiners in Objective Structured Clinical Examinations. However, we heard during the visit that the trust did not feel very much involved in curriculum development and undergraduate curriculum design at the medical school. However, the trust management team are aware of the changes in assessments introduced for clinical phase two and final year students. The education management team said they feel the curriculum has been 'handed down' from the medical school and they would like to be able to be more involved or contribute to curriculum changes.

### *Undergraduate clinical placements (R5.4)*

- 63** The trust is located adjacent to the medical school and is the main site for student placements. The location enables students to keep very close ties with, and access to, the medical school during the time they are allocated to NUH.
- 64** The medical students we met expressed their satisfaction with the educational experience at the trust. They appreciate the weekly prescribing teaching sessions and the access to simulation and enhanced technology teaching. They also praised the support and teaching they receive from clinical teaching fellows. The structured teaching sessions are useful, however students said they would find it useful if they were recorded and made available online for those who might not be able to attend.
- 65** Students commented particularly on the quality of clinical teaching, not only by clinical teaching fellows, but also the wider medical team and members of the interprofessional team. The students we met listed NUH as probably the best site for their placement.

**Area working well 3:** The students we met were complimentary of the environment at the trust, feel well supported and are particularly enjoying working with the teaching fellows.

*Training programme delivery (R5.9)*

- 66** The trust told us they work closely with HEE EM to deliver the national curricula for postgraduate training. Curricula delivery is discussed regularly at quality group meetings and its implementation is monitored through the college tutors and postgraduate school boards. Going forward, the trust will aim to discuss matters regarding postgraduate curricula in the Medical Education Committee meetings.
- 67** The doctors in training we met were satisfied overall with the training experience at NUH. This is supported by the data on the 2016 NTS where the majority of doctors in training responded positively to questions regarding their practical and educational experience at the trust. However, as highlighted earlier in this report, doctors in training did sometimes struggle to find the right balance between service delivery and training. F1 doctors said that their current placement at the trust enables them to meet all the requirements of their curriculum. The challenge between service provision and education was also recognised by the senior management and education management teams.

<b>Team leader</b>	Professor Jacky Hayden
<b>Visitors</b>	Professor Alastair McGowan Professor Anoop Chauhan Ms Katherine Marks Professor Peter McCrorie Dr Anna-Maria Rollin
<b>GMC staff</b>	Mr Kevin Connor Ms Elona Selamaj

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Date: 25/04/2017

**Re: GMC Visit 2016 - Report to Nottingham University Hospitals NHS Trust**

Dear Ms Llewellyn,

Further to your email correspondence of 14 March 2017, I should like to acknowledge receipt of the report related to the GMC visit to Nottingham University Hospitals Trust in October 2016.

We are very pleased with the findings presented in your detailed report that describe many areas of good practice, and in particular highlight that our students and doctors in training feel well supported, whilst appreciating the learning opportunities available and being complimentary about the training environment.

In addition we appreciate the recognition and support for the proposed reforms that are taking place to further strengthen educational governance within the trust. These new processes will be applied to allow us to address the requirements (Appendix A) that you have described in the small number of areas where improvements are necessary. We have been, and will continue to, work closely with the Health Education England East Midlands Quality team to monitor progress with our requirements and also to disseminate the areas of good practice that you have identified.

Yours Sincerely,



Dr Adrian Blundell  
Director of Postgraduate Medical Education  
Consultant and Honorary Associate Professor in Medicine of Older People

## Appendix A

### Requirements

#### **1. Theme one 1.12c; R1.16**

***The trust must look into the working patterns and levels of workload for doctors in training.***

Nottingham University Hospitals is a busy trust; this was acknowledged by trainees, trainers and senior management during the GMC visit. In fact, one of the highlighted strengths is the breadth and depth of experience the trainees described that can be gained by training here. The trust is continually aiming to improve the training versus service components to ensure the highest quality of training. We have, over the last 6 months, introduced a Medical HR department. This has enabled better oversight of doctors' rotas. The implementation of the new junior doctor contract and the appointment of two guardians of safe working hours have allowed a more proactive approach to rota reviews. As doctors in training move onto the new contract, they are required to have a detailed individualised work schedule. Our first doctors moved over to the new contract in December 2016 and so the process of work schedule reviews has commenced. Regular interrogation of exception reports has allowed timely changes to rotas where necessary to ensure working patterns are appropriate. We have also appointed a Junior Doctor Liaison Officer as a conduit to improve communication with our trainees. Several departments have implemented Advanced Clinical Practice programmes to aid with junior doctor workload. In addition we have started accepting student Physician Associates on placement and are now looking at the introduction of Medical Team Assistants / Doctor Admin Assistants.

#### **2. Theme one R1.13**

***The trust must ensure that all doctors in training receive an appropriate induction before undertaking on-call duties. This includes a departmental induction at each rotation for doctors in the foundation programme.***

The induction processes are reviewed annually and several new initiatives were introduced in August 2016. This led to our highest ever compliance rate for mandatory training and generally positive feedback. Our concentration over the next year is to review feedback to ensure induction is more bespoke, taking into account training level and also specialty, in order to reduce duplication. As we progress to increased electronic learning possibilities we hope to free up more time at the beginning of a rotation for more detailed local inductions. The DMEs are now linked to divisions and will work more closely with specialty leads to ensure appropriate induction. Our Junior Doctor Liaison Officer has induction as one of her portfolios of work and has now introduced an evaluation process for real time feedback. In addition we have introduced "doctor in training survival guides" in some departments with a plan to extend to all clinical areas.

### **3. Theme one R1.14**

***The trust must investigate the communication surrounding the process of tagging and transferring patients from the emergency ward to other hospital departments.***

At the time of the GMC visit, the new process of “Tagging” of patients had only been in place for a couple of weeks and so communication and learning strategies were still being implemented. “Specialty” tagging was introduced within the Trust with the aim of streamlining patient pathways by giving clear and early oversight of the intended specialty for emergency patient admissions. Communication around the process was strengthened following the visit. However, tagging has been somewhat confused with ‘referral’, specialties have ‘declined’ tags without managing patients and junior doctors have been left unclear as to consultant attribution.

Therefore the Division of Medicine has reviewed the tagging process with the relevant specialties, introducing a new Standard Operating Procedure, and will be working to re-organise the admission processes to remove any lack of clarity and provide better support to doctors in training working within the emergency pathway. Information regarding the process will be included in induction.

### **4. Theme three R3.3; R3.5**

***The trust must investigate and address the bullying and undermining concerns raised by F1 doctors.***

As the report describes, the overwhelming majority of doctors stated that there were no concerns about bullying or undermining and indeed felt that consultants, trainers and managers are supportive of doctors in training. It is therefore disappointing to here that a comment was raised about undermining at Foundation Year 1 Level. Nottingham University Hospitals NHS Trust has a robust set of values and behaviours which are clearly emphasised to all staff groups and indeed presented as part of induction. Since the visit we have been monitoring the situation closely and are not aware of any further concerns that have been raised but will be reviewing the Foundation Doctor end of placement surveys and also the 2017 GMC survey closely. Our support for our F1 doctors has increased with the appointment of our Junior Doctor Liaison Officer and we also now have a specific Foundation Doctor Forum as part of a Trust Wide Forum Network and so we are confident that concerns can be flagged in a timely manner.

## Recommendations

### **1. Theme one R1.7; R1.8**

***The trust should clarify and ensure that rotas for gastroenterology provide the appropriate level of supervision.***

Gastroenterology is a large speciality with 22 consultants bringing together a wide mix of specialism and experience. Our model of higher specialist training closely adheres to the standards set by the GMC and hence the recent GMC feedback has been unexpected. A vital part of learning is the availability of adequate supervision in the right environment. In order to facilitate this, the job plans for all the consultants have always had adequate time factored in. During the acute GI on-call in Queen's Medical Centre (QMC), consultants have all their usual clinical commitments cancelled and are available all day and night to directly supervise the StRs during the morning consultations and also during the afternoon endoscopy sessions. Senior trainees who have achieved all their competencies are given adequate freedom during these activities in order to further develop their decision-making skills with a consultant available in the immediate vicinity. In our recent audit, over 90% of all out of hours (OOH) endoscopies were performed by trainees with direct consultant supervision. In addition all StRs are allocated outpatient clinics and endoscopies which are under the direct supervision of the responsible consultant.

Our training model has been responsive to the trainee needs and based on feedback from our previous trainees regarding the lack of adequate endoscopy access, we have altered our endoscopy training model in the last 6 months with good outcomes (positive feedback). The recent HEE regional programme feedback on gastroenterology was positive for Nottingham University Hospitals.

There is also adequate educational governance with each trainee assigned an educational supervisor who has adequate time job planned for this activity in order to facilitate training, review their assigned StR's progress and to achieve agreed learning outcomes. In addition, we have now introduced training leads for endoscopy and gastroenterology.

In the light of the recent GMC review, regular StR meetings with training leads have been initiated in order to identify obstacles to training and to rectify problems at an early stage. Collective feedback (both positive and negative) obtained from trainees are planned to be discussed at the regular consultants' meetings.