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Ms Jennifer Barron  
Education Quality Assurance Project Manager  
General Medical Council  
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Dear Ms Barron

**Final Report of visit to Oxford University Hospitals NHS Trust in 2014/2015**

Further to your letter of 16 February 2015, I should like to acknowledge receipt of the report of the quality assurance visit to Oxford University Hospitals NHS Trust.

Undergraduate teaching and post-graduate training are an integral component of the work of our Trust as a Local Education Provider. Accordingly, the Board welcomes the external scrutiny from your well-qualified and independent experts as an important component in maintaining standards at both undergraduate and postgraduate levels. The acknowledgement in the report of the overall good standard of education across the organisation with some examples of high quality training and the identification of areas of good practice (supervision and support of trainees, foundation teaching, dementia awareness strategy) was particularly welcome.

The Trust has well developed educational governance processes in place to monitor our performance against GMC standards and these will be applied to address the requirements you have made on us to improve certain areas of our performance where we have fallen short of these standards. We are currently working with Health Education England Thames Valley to address these requirements and recommendations (Appendix 1) and also to more widely disseminate the strengths and innovations in medical education and training that you have identified in the report.

Yours sincerely



**Sir Jonathan Michael FRCP**  
Chief Executive

Copies:

Dr Tony Berendt  
Dr Peter Sullivan

## APPENDIX 1: RESPONSES TO GMC REPORT

### I. REQUIREMENTS

Requirement 1: " Current terminology must be used when referring to the grades of doctors in training and designing rotas to ensure appropriate clinical supervision and expectations of doctors' competence."

**The Trust is actively discouraging the use of the term "SHO" and is working towards ensuring that this term is not used on doctor's duty rotas.**

Requirement 2 : "Handover must be factored into all rotas for doctors in training".

**As part of the Care 24/7 project (this can be evidenced in the roll out at the HGH to date), we are advocating that the formalised handover meetings are incorporated into the rotas and include the incoming and outgoing staff. Streamlining the process using SBAR provides a platform to go through a Handover Process in a SMART way that will limit the time taken. It also emphasises the need for leadership and that opportunities for training and education within the process are utilised.**

**We are putting together a video that will reinforce these behaviours and we have engaged our juniors in the negotiations on shift times etc to date.**

**Examples:**

**1. Within AGM there is a planned overlap of 30mins in the evenings and 1hour in the mornings to allow handover and this is in the AGM handbook available on the intranet:**

#### **Handovers**

**When you go off duty you must hand over any active clinical problems to your colleagues on the incoming shift. Handover should be face-to-face so that you can give your colleague a list of patients of concern: there is sufficient overlap in the shifts to allow this to occur. You should ensure that the patients' notes always contain an up to date view of the problems and management plan. You should not hand over non-urgent tasks such as looking up routine blood results. Sick patients who need senior review whilst their firm is off duty should be handed over by the firm's SpR to one of the duty SpRs, e.g. the evening SpR for the night take, or the 'Hospital-at-Night' SpR. Specialty patients (geratology, cardiology and gastroenterology) needing review at night should be notified to the 'Hospital-at-Night' SpR not just the cover house officer.**

#### **Evening handover**

The evening take RMO should hand over the take to the incoming night RMO at 2100hrs. In addition, at 2139hrs every evening the Hospital-at-Night SpR (or evening take consultant if present) will lead a formal handover meeting for the outgoing take and evening cover staff to hand over patients who are likely to or may require attention during the night to the incoming night cover staff, there is a 30 min overlap built into rotas for this handover.

2. Horton handover is also built into the rota with a 30 minutes overlap period in the evening - 9.30-10pm. In the morning currently there is a 90 min overlap, this may change to 30 minutes, but not definite yet.

Requirement 3: "The recovery plan in neurosurgery must be implemented in full, the pace of implementation accelerated, and progress monitored and reported".

Difficult to respond as in reality, the 'low hanging fruit' of the recovery plan have been harvested and the other aspects will take a couple of years to come to fruition - full establishment, nurse practitioners, spinal surgery back in house etc... Most of these things require significant service investment. TME heard more about neurosurgery on 08 January - and the Clinical Director will go back with a resource request (which would allow substantial progress if approved) on 16 April 2015.

The trainees are not expected to work far in excess of the hours allowed by the EWTR; they may feel that they are doing so but they are not expected to be doing so. The new rota is EWTR compliant.

There is an additional neurosurgery junior trainee who can potentially be called back to the rota to provide support out of hours if a gap emerges. This also enhances neurosurgery training quality. There have been two banding exercises since August 2014. Both suggest excess hours however, there is no evidence that trainees are escalating overruns as required (in order to allow consultants and managers to provide compensatory rest). Communication continues in this regards. Further monitoring is planned in March 2015.

Requirement 4: "Clinical and educational supervisors in all departments, including undergraduate clinical teachers, must have an adequate allocation of time in their job plans for training."

Trust policy on this is that any consultant with bona fide teaching and training responsibilities who can demonstrate a substantial contribution to medical student teaching or post-graduate training will have this recognised in their job plan. The Trust has an agreed tariff for educational supervisors and named clinical supervisors. This position is endorsed by both the Trust Education and Training Committee and the Joint University-Trust education committee and has the support of the Medical Director, the

**Director of Clinical Services and the Director of Organisational Development and Workforce.**

Requirement 5: "Learning opportunities in cardiothoracic surgery must be integrated into service provision to ensure that doctors in training are able to progress appropriately within their training."

**Learning opportunities for trainees in cardiothoracic surgery have been further integrated into service provision by the advent of the new cardiothoracic rota at the beginning of February 2015. This rota was designed to address issues raised by trainees regarding enhanced theatre training time and an opportunity for designated time for administration, statutory and mandatory training, audit and research.**

The department has not yet performed formal assessment or sought feedback however unsolicited comments below have been received, welcoming the ability to plan ahead, to ease and increase knowledge of patients and provide continuity of care. With regards the effect of its instigation on increased training in theatre, I have attached record of training of one of our two NTN's. Given that this month will reflect one of his lighter theatre periods as it contains significant on call commitment, which will not recur for a number of further months, we feel that the in theatre training has been significant. We hope this reassures the review group that NTN's exposed to theatre time receive excellent training opportunities. Formal feedback and review at HETV will occur in July 2015.

**Unsolicited feedback re: new rota:**

*Dear Ms Belcher and Ms Slater*

*I want to thank you both for this new rota. The ability to plan the next number of months is great and I know in advance when my theatre slots are has been a great help.*

*I like that there are a few days in a row on call as it's easier when you know the patients and there is a continuity of care.*

*It's early days but thus far I feel it is a good rota. I have a run of nights into days the week after next which will be interesting to see how the body clock functions after but the last set of three nights was tough but manageable.*

*We need to make sure that theatre 'days' remain theatre days within the thoracic side of things which I will hope they will be and by abolishing the second thoracic rota this will help.*

## II. RECOMMENDATIONS

Recommendation 1: "The relevance of secondary care placements for GPSTs should be increased."

**It is acknowledged that there have been difficulties with consultants in secondary care not being aware of the curricula requirements of GP trainees. The DME is now meeting**

**regularly with the GP trainers to work through a process of addressing this department by department. Progress in this will be monitored by the School of General Practice**

Recommendation 2: "The quality of online induction and training materials, departmental induction in some specialties, and the information provided to medical students when starting placements should be improved."

**No departmental induction is undertaken online. There is a 'hospital orientation' eLearning package which is over and above the induction requirements. As part of the GMC 'Recognition of Trainers' process we are developing named clinical supervisors in each Division who will have specific responsibility for ensuring adequate induction in each department of that Division.**

Recommendation 3:" Feedback on incidents and serious incidents should be provided to all doctors in training, who either report or are involved in an incident to ensure the educational opportunities afforded by quality and risk management processes are being maximised."

**We now have a system in place that allows trainees (or anybody) who activates a Datix report to obtain feedback by the simple expedient of putting a notice on the front page of the reporting system which informs the reporter that they can contact <Datix@ouh.nhs.uk> to email for details of the outcome**