

Visit to Oxford University Hospitals NHS Trust

This visit is part of a regional review and uses a risk-based approach. For more information on this approach see <http://www.gmc-uk.org/education/13707.asp>.

Review at a glance

About the visit

Visit dates	20-21 October 2014
Sites visited	John Radcliffe Hospital and Nuffield Orthopaedic Centre
Programmes reviewed	John Radcliffe Hospital: undergraduate Oxford Medical School, foundation, general practice in secondary care, histopathology, cardiothoracic surgery, neurosurgery. Nuffield Orthopaedic Centre: undergraduate Oxford Medical School, sport and exercise medicine, trauma and orthopaedic surgery.
Areas of exploration identified prior to the visit	Patient safety including hospital at night, workload and staffing issues, support for doctors training in surgical departments, handover and induction, transfer of information, use of quality data, governance of education, GP training in secondary care, transferable practice in histopathology, dementia awareness, training and support for trainers, relationships with Oxford Medical School and Health Education Thames Valley.
Were any patient safety concerns identified during the	No

visit?	
Were any significant educational concerns identified?	No
Has further regulatory action been requested via <u>enhanced monitoring</u>?	No

Summary

- 1 Thames Valley was selected for the 2014-15 regional review, this includes Health Education Thames Valley, Oxford Medical School, Buckingham Medical School and three chosen local education providers. The John Radcliffe Hospital and Nuffield Orthopaedic Centre are both part of Oxford University Hospitals NHS Trust, a large NHS trust with four sites around Oxford. The John Radcliffe Hospital is a large secondary and tertiary care hospital and trauma centre with over 450 doctors in training across all levels. The Nuffield Orthopaedic Centre is a specialist orthopaedic hospital with more than 30 doctors in training.
- 2 We have been monitoring surgical training for foundation doctors at the John Radcliffe Hospital, we found some important improvements had been made during the course of the visit. We will continue to monitor progress against some issues related to workload and support at night in surgery through other established processes.
- 3 We found that a good standard of education was being delivered across both the John Radcliffe Hospital and Nuffield Orthopaedic Centre and we found several examples of high quality training. Our evidence base identified a number of areas where training appeared to be working well and these were investigated as potential good practice. We found our evidence to be correct and noted that doctors training in trauma and orthopaedics and sport and exercise medicine at the Nuffield Orthopaedic Centre were receiving an excellent and supportive experience. We are currently monitoring a concern relating to histopathology training at another hospital in Thames Valley. Our evidence suggested the quality of training was better at Oxford University Hospitals and we investigated whether there were any transferable learning practices from the training provided at the John Radcliffe Hospital. We found that doctors training in histopathology at the John Radcliffe Hospital were receiving an excellent experience, and there are potential learning points for other places providing histopathology training in the region as outlined below. Some of what occurs in histopathology at the John Radcliffe can be replicated elsewhere but a whole programme review will need to be undertaken by Health Education Thames Valley as currently all ST1-2 doctors rotate through smaller centres with higher doctors in training in less service oriented posts are based at the John Radcliffe.
- 4 Oxford Medical School students based at the John Radcliffe Hospital also reported excellent teaching and supervision. There were some examples of important changes made to address problematic areas, such as the experience of foundation doctors in the surgical emergency unit at the John Radcliffe Hospital and general practice specialty trainees (GPSTs) working in paediatrics at the Horton Hospital. There have been considerable efforts made by the educational leadership to achieve these improvements and it was clear that there is a high level of awareness of educational

issues amongst the senior management team who showed evidence of communicating effectively about the issues.

- 5 Despite the important progress made in some areas, we did also find areas where improvements are incomplete or where further progress is required. There is a good understanding of many of the issues but there is still progress to be made in neurosurgery and in cardiothoracic surgery training. Doctors in training identified improvements that could be made to cardiac surgery and we heard there was the intention to reapply for approval of thoracic training posts. We also found a number of outstanding issues with the experience of foundation doctors in the surgical emergency unit, and that the excellent experience provided for GPSTs in paediatrics at the Horton Hospital was not always replicated at other sites and specialties. Similarly, there are continuing challenges in relation to support for doctors in training in both medicine and surgery wards at night. Recovery plans have been developed but progress against them could be accelerated.
- 6 We also identified a potential need for improvements to handover and induction, and, despite the efforts of the education management team, the continued use of outdated terminology for doctors' training grades. Many of those we spoke to also identified the impact of service pressure on their ability to train or teach as an issue. Although there are plans to include time in job plans these are not consistent with the Health Education Thames Valley approach and the plans are less defined and protected for the teaching of medical students.
- 7 Although we noted some areas for improvement, our overall findings in relation to the John Radcliffe Hospital and Nuffield Orthopaedic Centre were positive. Education and training benefit from enthusiastic and committed trainers who offer an environment which is largely supportive and offers a wide range of learning opportunities. Teaching is mostly well received, particularly that provided to doctors on the foundation programme and there is a clear commitment to improvement by the leadership which is backed up by a good understanding of the issues.

Areas of exploration: summary of findings.

This section identifies our findings in areas we agreed to explore prior to the visit.

Patient safety/hospital at night

Students and doctors in training reported that they are well supervised and have good access to support when required during the day. There are excellent arrangements for night cover in trauma and orthopaedics at the Nuffield Orthopaedic Centre; however the consultants are resident at the John

Radcliffe Hospital to cover the trauma service.

The senior management at the John Radcliffe Hospital stated their view that whilst there is good support and supervision during the day, doctors in training covering wards at night experience difficulties with the workload, as they are required to cover other specialty wards other than the those where their work is based ('cross cover'). They also experienced problems with handover (see below) and accessing support from more senior doctors in training and consultants. This was confirmed by doctors in training in the foundation programme, as well as some general practice doctors training in secondary care posts and higher surgery training, and their supervisors. There are clearly continuing challenges in relation to hospital at night at the John Radcliffe Hospital.

We are already monitoring ongoing issues with night cover in some surgical departments. Oxford University Hospitals NHS Trust is attempting to address these issues in a number of ways, including running events modelled on risk summits to identify and plan potential solutions. We will continue to receive updates on progress in relation to these issues, including the outcomes of the risk summit style meetings through our established processes.

We heard that critical incidents involving doctors in training, which do not meet the threshold for reporting to Health Education Thames Valley, are now collated by a dedicated administrator and reviewed by the director of medical education to identify if there is any further learning required. We heard an example of feedback given about prescribing practice as a result of this process. We found limited awareness of the process amongst the doctors in training we met, although some supervisors were aware of the process. We support the development and expansion of this process and encourage its use to improve patient safety at the local education provider.

We will continue to monitor issues related to hospital

	<p>at night in the surgical departments through pre-existing arrangements.</p>
<p>Workload</p>	<p>In most departments workloads were manageable, safe and allowed students and doctors in training to access educational opportunities. However, we heard about some departments where the workload had impacted on educational experience or supporting tasks, such as induction. Workload at night also remains at issue at the John Radcliffe Hospital (see above).</p> <p>We noted some impact from workloads on the provision of undergraduate teaching at the Nuffield Orthopaedic Centre and in some surgical speciality training.</p> <p>See requirement 3 and recommendation 1</p>
<p>Support for doctors training in surgical departments</p>	<p>We identified improvements in the experience of foundation doctors working in the surgical emergency unit which had been identified as a risk. We also noted some improvements to the experience in neurosurgery and cardiothoracic surgery although there are still areas for improvement in each of these departments. We noted there is a good understanding of many of the issues and a commitment to address some outstanding issues but find that progress towards implementation of the recovery plan has been slow.</p> <p>See improvement 1, See requirement 3 and recommendation 1</p>
<p>Handover and induction</p>	<p>We found generally good arrangements for handover across both the John Radcliffe Hospital and Nuffield Orthopaedic Centre; however, we found that handover was not routinely factored into rotas in some specialties at the John Radcliffe Hospital.</p> <p>See requirement 2</p> <p>The trust induction was well received by doctors in training and we found examples of excellent departmental inductions at the John Radcliffe Hospital, such as in paediatrics, vascular surgery and</p>

	<p>to the surgical emergency unit for foundation doctors, and for doctors training in cardiothoracic surgery. We did note some variability in the quality of departmental induction and heard of technical problems hampering induction in some areas. We also identified some improvements that could be made to the information provided to medical students before starting their placements.</p> <p>See recommendation 2</p>
<p>Transfer of information</p>	<p>Doctors training in cardiothoracic surgery work across Health Education Thames Valley and Health Education Wessex. We found transfer of information between the two organisations and John Radcliffe Hospital to be working adequately. We also heard that supervisors of foundation doctors receive data from the education centre in a timely and effective manner. There were some issues beyond the control of Oxford University Hospitals NHS Trust about the content of information transferred to the foundation programme, but we are content that local systems for transferring information are sound.</p> <p>Standards are being met in the aspects of transfer of information that we explored on this visit.</p>
<p>Use of quality data</p>	<p>We heard that data about the quality of service and training was escalated through the management structure. We found a good awareness of issues in training amongst the senior management team, and appropriate use and reporting of quality data. We noted plans to use incident reporting to help provide formative learning experiences for doctors in training and commitment to further developing the use of data to support the quality management of education.</p> <p>Standards are being met in the aspects of use of quality data that we explored on this visit.</p>
<p>Governance of education</p>	<p>We saw evidence that there are good links between the education management team and the general management and board. We heard that the board receives an education focused report and that education is covered in some of the subcommittees,</p>

	<p>such as the quality committee, which is chaired by a non-executive director. Senior management demonstrated a good understanding of the state of education and training, and board members were able to identify examples of issues relevant to education raised through reporting. While the post of director of medical education is very new compared to other hospitals in the region, we saw evidence that this role, and its current incumbent, is effective in representing educational issues.</p> <p>Standards are being met in the aspects of education governance we investigated during the visit.</p>
<p>GP training in secondary care</p>	<p>We heard that the experience of GPSTs at the different sites and departments within Oxford University Hospitals NHS Trust was variable. GPSTs reported that there was limited opportunity to tailor their secondary care placements at the John Radcliffe Hospital to their future careers as general practitioners; many GPSTs did not feel that all of their secondary care placements were educationally relevant. We also found there was relatively limited engagement with the curricular requirements and specific educational needs of GPSTs by their clinical supervisors at the John Radcliffe Hospital and Nuffield Orthopaedic Centre.</p> <p>The GPSTs we met did note there had been some recent improvements to their experience, such as the introduction of a week-long placement in community paediatrics within their six month paediatrics posts at the John Radcliffe Hospital. This provided experience of outpatient paediatrics which is highly relevant to general practice. We also found that previous poor experience for GPSTs in paediatrics at the Horton Hospital had been addressed and that the placement now offered excellent training that was engaging and highly valued by the GPSTs. We consider there are important lessons which could be applied across the other departments from this experience.</p> <p>See recommendation 1</p>
<p>Transferable practice</p>	<p>We found that the histopathology department at the John Radcliffe Hospital was providing a good</p>

<p>in histopathology</p>	<p>educational experience; the service is largely consultant delivered and doctors in training were able to maximise learning opportunities as a result. We also heard that the department supported doctors in training by tailoring clinical experience to their individual learning needs. Although the high ratio of trainers to doctors in training cannot easily be replicated elsewhere without a programmatic review by Health Education Thames Valley the supportive approach to educational supervision provided can be disseminated.</p> <p>Standards are being met in the aspects of histopathology training that we explored on this visit.</p>
<p>Dementia awareness</p>	<p>We found there is an excellent dementia awareness programme across Oxford University Hospitals NHS Trust. The programme involves interdisciplinary training for staff, improvements to the management of patients with dementia admitted to wards, and development of resources for carers. Students and doctors training in trauma and orthopaedics commented that the training for clinicians was excellent and several stated that they used their learning from this training on a day to day basis.</p> <p>See good practice 4</p>
<p>Training and support for trainers</p>	<p>Oxford University Hospitals NHS Trust has a strategy for the recognition and approval of trainers. There are plans for the development of a 'named clinical supervisor' to take responsibility for training in each department. It was not clear to us how time would be accounted and protected in the job plans of those who provide day to day clinical supervision, on the ward teaching and complete supervised learning events.</p> <p>Most educational supervisors whom we met, had time allocated in their job plans for the role, although we were unclear whether the actual allocation of time for postgraduate training was in accordance with guidelines from Health Education Thames Valley. It was also unclear how time for undergraduate education was incorporated into job plans and we heard that undergraduate teachers</p>

	<p>largely worked on good will but that Oxford University Hospitals NHS Trust has committed to providing recognition in the next round of job planning.</p> <p>We heard that undergraduate and postgraduate teachers and trainers were supported to attend training and courses.</p> <p>See requirement 4</p>
<p>Relationships with Oxford Medical School and Health Education Thames Valley</p>	<p>Oxford University Hospitals NHS Trust has a close relationship with the University of Oxford Medical School and enthusiastic and engaged teachers deliver a generally high standard of undergraduate education at the John Radcliffe Hospital. The delivery of undergraduate education is managed by the School and there is a joint committee between the School and the trust at which issues can be discussed. There are several staff with key roles across both organisations, allowing good communications between both organisations. We were unclear about how resources, particularly time in consultant job plans, are allocated to undergraduate teaching by Oxford University Hospitals and consider this area could be improved.</p> <p>See requirement 4</p> <p>We heard that there were a range of Health Education Thames Valley meetings in which Oxford University Hospitals NHS Trust participates and it is represented on the Health Education Thames Valley board. There is also regular reporting to and scrutiny by Health Education Thames Valley of the Oxford University Hospitals NHS Trust risk management of education.</p>

Areas of good practice

We note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further.

Number	Paragraph in <i>Tomorrow's Doctors (TD)/ The Trainee Doctor (TTD)</i>	Areas of good practice for the local education provider
1	TTD1.2, 5.1, 5.20	Arrangements in trauma and orthopaedics ensure that doctors training in the specialty are well supported and supervised and have good access to training opportunities and teaching.
2	TTD 2.3, 6.2, TTD S2.1	Foundation training benefits from a well-designed and delivered teaching programme. There is also a local forum for foundation doctors, a subset of whom also sit on the Health Education Thames Valley regional foundation forum.
3	TTD 6.2	The histopathology service at the John Radcliffe Hospital is designed to maximise educational opportunities for doctors training in histopathology. There are structures to identify the learning needs of doctors in training and provide an educational experience in the department which is tailored to suit individual requirements.
4	TTD 6.16, 6.33 TD 104	The multi-professional training offered on treating patients with dementia is valued by students and doctors in training.

Good practice 1: Supervision and support for trauma and orthopaedic surgery training

- 8 Trauma and orthopaedics at the Nuffield Orthopaedic Centre has consistently performed well in the national training survey, achieving better than average results for handover, access to educational resources and regional teaching in 2014. The local education provider has maintained this performance against all these results since 2012, with the exception of access to educational resources which achieved an average score in 2013. Trauma and orthopaedics training in Oxford is split between the John Radcliffe Hospital, which is the trauma centre, and the Nuffield Orthopaedic Centre. Doctors in training rotate between the two sites to do trauma placements and orthopaedic placements.
- 9 Doctors training in trauma and orthopaedics were happy with the configuration of the service, noting that there was very little need to provide cover across both sites and

that the rotas for each site are separate. We heard there were excellent supervision arrangements at the Nuffield Orthopaedic Centre, with support from a trauma and orthopaedics consultant and geriatric medicine clinician being present at all times and a strong patient safety culture driven by the consultant supervisors.

- 10** There is a strong educational focus on the programme: the doctors in training we met praised the enthusiasm and dedication of their clinical teachers and supervisors and stated that teaching at the Nuffield Orthopaedic Centre was excellent and frequent. There are also good academic opportunities at Oxford University Hospitals NHS trust in partnership with the University of Oxford. These provide a good environment for doctors seeking opportunities to gain out of programme research experience and we noted that a large number of the doctors in training we met had completed PhDs with the support of Oxford University Hospitals NHS Trust.
- 11** Overall, we found that doctors training in trauma and orthopaedics at the John Radcliffe Hospital and Nuffield Orthopaedic Centre were receiving excellent training. There are elements of the way the service is delivered and supports training that are not currently replicated in other organisations. It was clear that doctors in training valued the experience and scope for intensive training offered by the dedicated orthopaedic service at the Nuffield Orthopaedic Centre and the excellent consultant support which was made possible by the size of the service. Nevertheless, we consider that the configuration of the service and support provided has resulted in excellent training, aspects of which may be transferable to other large trauma centres.

Good practice 2: The teaching programme and representative forum for foundation doctors

- 12** We found much to be positive about the teaching programme and representative forum for foundation doctors. While we noted problems in the experience of foundation doctors in some departments, we found that local foundation teaching and representation was well supported by the education management team. The documentation we reviewed indicated that there was an active committee managing foundation teaching locally, which conducted regular and thorough consideration of the teaching programme. We were impressed by the quality and analysis of the evaluation data collected and the consideration of teaching and learning strategies conducted by those responsible for foundation teaching at a recent away day.
- 13** Foundation doctors we met in both years of the programme were enthusiastic about the local teaching they received, advising that it was extremely well organised and clinically focused. They noted there was a member of staff allocated to hold the foundation doctors' 'bleeps' (a pager used to request jobs from a doctor), ensuring that the training was uninterrupted. Clinical supervisors we met stated that a curriculum for the local foundation teaching had been designed by a consultant who was familiar with the requirements of the foundation programme and the expected

level of competence of graduates because they had previously been both foundation director at the trust and director of clinical studies at the University of Oxford Medical School. We also heard that the recent away day had been used to revise the teaching programme, with the intention of creating more interactive sessions. It was clear from our discussions and analysis of the supporting documents that the foundation teaching programme is well designed and delivered, and subject to regular and considered review by those responsible for it.

- 14 There is also a forum for foundation doctors, which meets fortnightly with the director of medical education. While this is not unique, we noted there was a good level of engagement with the forum by the education management team. Foundation doctors we met gave examples of issues they raised at the foundation forum, noting that the group was involved in the recent audit of induction at the trust. We also heard across a number of meetings with doctors in training and foundation supervisors that the education management team were visible and approachable, and that foundation doctors were aware of the forum as a route for raising issues with the education management team.
- 15 It was clear that there are good mechanisms to support foundation doctors to raise issues about their training. We were also impressed by the management and regular review that takes place which ensures local foundation teaching is of a high standard.

Good practice 3: The organisation of the histopathology service to benefit education

- 16 We found that the histopathology department at the John Radcliffe Hospital was well designed to help doctors in training meet the requirements of their curriculum. Doctors in training we met reported a supportive environment in both academic and pastoral terms and were pleased with the experience they were getting. We heard there was a wide range of clinical experience available, with the mix of cases presenting good learning opportunities that were maximised by the department. We were also told that supervisors in the department were approachable, and there is a specific consultant appointed to take a lead on pastoral issues in addition to the wider training programme structure.
- 17 We heard that the configuration of the department was highly supportive of histopathology training: the service is consultant delivered and doctors in training reported they could participate in cases that maximise their learning opportunities. Doctors in training can ask to carry out certain types of cases so that they can fill gaps in their knowledge or coverage of the curriculum, and we did not hear of any instances where the requests had been refused.
- 18 Doctors in training also stated that they received good feedback on their performance from their supervisors in the department. We heard that feedback was generally

timely and constructive. Doctors in training receive a formative assessment at the end of each attachment which is used to identify areas for personal development. Doctors training in histopathology we met stated that this was useful and well managed, and that they could discuss the feedback from this assessment easily with a supervisor.

- 19 Doctors in training also noted they could undertake specific patterns of working to support their development: we heard an example where a doctor in training was assigned to a specific consultant to gain experience of a particular type of histopathology which had not been covered adequately in their previous placement. Supervisors we met confirmed that they could tailor the placements to the learning needs of individual doctors in training. They also gave examples of how they had designed specific tailored programmes to support doctors in training to gain experience required to pass Royal College of Pathologists fellowship exams, which are required for doctors to progress in their training programme.
- 20 It was clear that doctors in training valued their experience in histopathology at the John Radcliffe Hospital; the histopathology department is configured to maximise opportunities for training. We also found that supervisors in the department have systems for identifying and feeding back on areas of weakness of individual doctors in training, and then for designing their clinical experience accordingly. Overall we were impressed by the quality of training delivered by the department and the systems used to achieve this level of quality. Experience here can be used to inform a whole programme review and other sites training doctors in histopathology in the region.

Good practice 4: The impact of Oxford University Hospitals' dementia strategy on the experience of students and doctors in training

- 21 Documents from a recent Health Education Thames Valley quality visit to Oxford University Hospitals NHS Trust highlighted the dementia awareness work as positive. Oxford University Hospitals NHS Trust has a strategy for dementia awareness which involves improvements to the identification and care of dementia patients admitted to wards and a programme of multidisciplinary training for staff.
- 22 In terms of clinical care, patients admitted to wards with dementia, or other cognitive impairments, are identified with a symbol of a daisy to ensure that clinicians working on the wards are aware of the patient's condition. Foundation doctors we met also stated that the large proportion of patients admitted to wards with dementia poses particular challenges in terms of prescribing. We heard that this has been addressed by the introduction of a pharmacist-led ward round, during which the pharmacist can prescribe for patients who do not have all their prescription medication with them when they are admitted to a ward.
- 23 Staff training is also a key part of Oxford University Hospitals NHS Trust's dementia awareness work and we heard enthusiastic reports from students and doctors in

training about this work. Students we met had received this training and gave positive evaluation, they stated that the learning they had received was applicable to many of their clinical placements.

- 24** Doctors in training also identified a number of benefits of the dementia training. Doctors training in trauma and orthopaedics praised the understanding of dementia issues by the trauma service and the contribution that this had made to the delivery of cross team working, and believed this had improved the care delivered to patients with dementia. Foundation doctors we met also showed a positive engagement with the dementia awareness training and noted how their quality improvement projects had been aligned to the strategy, for example in the form a dementia screening quality improvement project.
- 25** We considered that, in addition to its direct impact on clinical care, the dementia awareness work at Oxford University Hospitals has made a positive impact on education. Students and doctors in training we met were clear that the training had informed their own clinical practice and considered it to be of a high quality.

Areas where there have been improvements

We note improvements where our evidence base highlighted an issue as a concern, but we have confirmed that the situation has improved because of action that the organisation has taken.

Number	Paragraph in <i>Tomorrow's Doctors (TD)/ The Trainee Doctor (TTD) Doctor</i>	Areas where there have been improvements
1	TTD 1.2, 1.3, 1.11	The steps taken to improve the support and supervision for foundation doctors working in the surgical emergency unit at the John Radcliffe Hospital. While some issues remain, there is an acknowledgement that further work is required and will be supported.
2	TTD5.1	The quality of paediatric placements for GPSTs at the Horton Hospital has been improved significantly; there is potential for this to be shared more widely across the other sites within Oxford University Hospitals NHS Trust.

Improvement 1: Support for foundation doctors working in the surgical emergency unit

- 26** Previous visits by the General Medical Council and Health Education Thames Valley and documentation submitted by Oxford University Hospitals NHS Trust in advance of the visit identified several serious risks to education and safety in the surgical emergency unit. The specific risks identified related to the way the surgical emergency unit was run primarily by foundation doctors, who received little support and supervision for their role from more senior doctors and few ward rounds. Problems were particularly acute overnight. Some of the documents we reviewed also noted a lack of teaching being delivered to foundation doctors in these posts. The national training survey results for 2014 also show below average results for F2 doctors in surgery against the indicators for workload and overall satisfaction.
- 27** One of the documents we reviewed in advance of the visit was a report on the problems in the surgical emergency unit by the director of medical education which set out many of the issues clearly and proposed a number of possible actions. During the visit, we investigated the extent to which the actions suggested in the report had been addressed.
- 28** Both the F1 and F2 doctors we met were aware that considerable changes had been made to the surgical emergency unit. F1 doctors we met stated that ward rounds were now taking place twice a day with a middle grade doctor and consultant, and that there were often ward rounds to review imaging. They also noted a doctor in training at CT1-2 level had been appointed to cover the surgery wards whom they could call if additional help was needed, that a middle grade doctor often supported triage, and that consultants, particularly those who were working on acute admissions, could be contacted and were supportive. A number of advanced nurse practitioners have been recruited to support the ward, and it was clear these staff were extremely highly valued by the F1s we met. The F2 doctors we met confirmed that ward rounds were taking place and that additional support had been provided. The F2 doctors also noted that a handbook for F1s working in general surgery had been produced, which the F1s we met knew about and found useful. It was clear from our conversations with foundation doctors that many aspects of the experience in the surgical emergency unit had been greatly improved.
- 29** We found that despite the improvements, there are outstanding issues with handover (see [requirement 2](#)). However, we heard that these issues are recognised and there is a commitment to supporting further improvement in this area by the education management team.
- 30** From our discussions with foundation doctors, it was clear that the additional support provided has resolved many of the problems in the surgical emergency unit. While we noted some continuing issues with handover and rotas for foundation doctors, these issues were well understood by those we met and we heard that work to make further improvements would be supported by the senior management team.

Improvement 2: Paediatric placements for GPSTs at the Horton Hospital

- 31** We investigated changes made to the GPSTs' paediatrics placement at the Horton Hospital in Banbury, which is part of Oxford University Hospitals NHS Trust. A Health Education Thames Valley visit identified that the placement provided a good experience for GPSTs and that recent changes had resolved issues with undermining and support.
- 32** We found that there had been an active and successful attempt to enhance the relevance of the placement to GP training. GPSTs we met advised that the quality of the paediatric placement at the Horton Hospital is very high, and that the placement was focused on enabling GPSTs to develop skills useful to their future careers. The placement has been redesigned with a different role for GPSTs to that of doctors in paediatric speciality training. Clinical supervisors of GPSTs we met at the John Radcliffe Hospital were aware of the design of the placement and confirmed GPSTs in this post had a separate educational programme. They also noted that GPSTs were supervised directly by consultants in the placement to ensure that reported issues with GPSTs feeling unsupported were reduced. The Health Education Thames Valley visit also noted a good awareness amongst supervisors in the GPST paediatric placement at the Horton of the requirements of the GP curriculum as they related to their placement.
- 33** We were impressed with the account given of general practice training at the Horton by the GPSTs and supervisors we met at the visit; it is clear that the department has been successful in providing a valuable experience for GPSTs through a detailed consideration of their educational needs. We noted several departments in the John Radcliffe Hospital and Nuffield Orthopaedic Centre where this experience could be disseminated and replicated.

Requirements

We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards. If these requirements are not met, we can begin to withdraw approval.

Number	Paragraph in <i>Tomorrow's Doctors (TD)/ The Trainee Doctor (TTD)</i>	Requirements for the local education provider
1	TTD 1.2	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.

2	TTD1.6	Handover must be factored into all rotas for doctors in training.
3	TTD 5.1, 5.2	The recovery plan in neurosurgery must be implemented in full, the pace of implementation accelerated, and progress monitored and reported.
4	TTD 8.4, TD157	Clinical and educational supervisors in all departments, including undergraduate clinical teachers, must have an adequate allocation of time in their job plans for training.
5	TTD 5.1, 6.10, 8.1	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.

Requirement 1: Use current terminology for grades of doctors in training and when designing rotas

- 34** We noted some use of out of date terminology including 'SHO' to describe doctors in training from F2 to CT2, and in some cases up to ST3, and the rotas they worked on. This could lead to confusion about the expected level of competence of the doctor in training, especially when sharing on-call commitments.
- 35** It was clear that the term remains in widespread usage at the John Radcliffe Hospital. We met with doctors in training across several different specialties and they confirmed that while there were slightly different uses of the term 'SHO' across departments, the term was often used to describe doctors from a range of grades, and to describe some first on-call rotas. While they did not necessarily identify patient safety issues resulting from this, doctors training to be GPs and in neurosurgery both stated that this represented a poor educational experience, particularly for the more senior doctors participating in this first on-call rota. The education management team acknowledged that combining F2-ST3 grade doctors in neurosurgery with little differentiation in their work programmes based on experience or career aspirations was not ideal for the doctors in training, but noted that it stemmed partly from the configuration of the neurology/neurosurgery ward and the demands of the service.
- 36** We did find that efforts are made to ensure that current terminology is used by some supervisors and the director of medical education. Supervisors in neurosurgery advised that they did not personally use the term 'SHO' to refer to doctors in training in neurosurgery. We also noted that the education management team discourages use of the term, although this was not always reflected in the clinical departments or by the doctors in training themselves.

37 While some action has been taken to ensure current terminology is used, the term 'SHO' does continue to be used to describe both doctors in training and on rotas. Although our visit did not identify any specific patient safety issues stemming from this, the terminology does encompass a wide range of competencies and can lead to confusion about the competency level of individual doctors in training. This is particularly the case in some departments within the LEP when grades up to ST3 are included. Aside from the safety considerations, both doctors in training and the education management considered that this arrangement does not always provide a good educational experience for ST2-3 doctors in training in some departments. Current terminology must be used when designing rotas and referring to doctors in training.

Requirement 2: Ensure handover is routinely factored into all rotas at the LEP

38 We found that handover arrangements, particularly for more junior doctors in training in surgery departments, were not yet meeting our standards. Oxford University Hospitals NHS Trust is working to improve the support for doctors training in surgery and has made significant progress in some areas (see [area of improvement 1](#)). However, the documentation it provided identified handovers as a persistent issue across the John Radcliffe Hospital, and the 2014 national training survey identified a number of departments which achieved below average results for handover.

39 One of the other changes identified by foundation doctors and supervisors was that the gastrointestinal surgery ward has been split into distinct 'hot' (acute admission) and 'cold' (scheduled admission) services, and there are also separate handovers within the different subspecialty wards in surgery. Clinical supervisors of foundation doctors noted that this was done to provide a better handover period for the more senior doctors in training, but that the rotas for foundation doctors had not yet been aligned to this model. This was reflected in our discussions with foundation doctors who stated that under this system it was difficult to have an effective handover period, as the rotas did not always have an overlap period which could be used for handover. As the hot and cold services in gastrointestinal surgery and different specialty wards (vascular surgery and the surgical emergency unit) all shared a single rota for cover at night but had separate handovers, some doctors in training were required to attend up to three separate handovers. The foundation doctors we met stated that on some occasions it was not possible to attend all of them. Some of the F1s we met also considered that replicating the electronic handover system used by the medical department in surgical specialties would support a better handover.

40 The education management team stated that they intended to align the rotas for the foundation doctors to the new system. They anticipate this would resolve the problems with foundation doctors having to stay beyond rota hours to attend handover and having to attend multiple different handovers. We noted that the education management team was committed to resolving this issue and consider it should be a priority. The local education provider must ensure that handover is

routinely factored into rotas for doctors in training as a matter of patient safety as much as for educational benefit.

Requirement 3: Accelerate implementation of change in neurosurgery

- 41** Data from the 2014 national training survey identified a number of possible risks in neurosurgery, with the John Radcliffe Hospital achieving below average results for overall satisfaction, adequate experience, workload, access to educational resources and local teaching. We also reviewed a number of documents supplied by Oxford University Hospitals NHS Trust in response to a visit by Health Education Thames Valley which noted issues with the level of support and supervision provided to doctors working in neurosurgery, and the educational opportunities available in the role. A 'recovery plan' has been developed for neurosurgery training which outlines many of the issues as well as tracking actions taken to make improvements to the training experience. The recovery plan collates concerns from a number of sources, including Health Education Thames Valley visits and the national training survey, identifying workload, imbalance between service and training, access to training opportunities, administration of certain procedures, rota management and support from nursing staff.
- 42** We also reviewed documentation from Oxford Medical School and survey data from their students concerning relatively low student satisfaction with neuroscience placements. We explored whether this was related to risks in postgraduate training but it was clear from our conversations with students based at the John Radcliffe Hospital that the issues with undergraduate placements stemmed from the design of the placement. Students we met stated the neurosurgery department was very receptive to undergraduates and provided a good learning experience. Doctors training in neurosurgery also stated that while there were difficulties in the department, the supervisors were supportive of their training and gave the impression that this increased their tolerance of some of the difficulties they had.
- 43** We asked doctors in training in neurosurgery about improvements made as a result of the recovery plan and they noted that there had been some important changes in some areas. We heard that scheduled teaching in the department had improved considerably, that there was some protected theatre time for doctors in training, and that new rotas had been arranged. We also heard that there were more F2 doctors on wards to provide cover, which allowed the ST1 and ST2 doctors to rotate to neurology and intensive care in line with curricular requirements. We were able to confirm that there had been some demonstrable improvements in the service by the time of our visit.
- 44** Despite these improvements, doctors training in neurosurgery did have some important ongoing concerns about their training. While they noted some recent improvements to the nursing support in the department nursing staff turnover was still high, they also expressed anxiety that failure to develop and recognise the skills of the nurses would lead to continued attrition. There was also significant

dissatisfaction with the single rota comprising F2 'SHO' doctors and ST1-ST3 level doctors training in neurosurgery (see also [requirement 1](#)). ST1-3s considered that the role remains relatively limited in terms of neurosurgical training opportunities, despite recent attempts to schedule more training opportunities. Doctors in training we met also stated that there was limited educational development of the role between ST1 and ST3 levels. They suggested giving greater responsibilities to ST3 doctors under the supervision of neurosurgeons who had completed their training and were undertaking a fellowship in the department. We also heard that the lack of educational development in ST1-3 makes it difficult for doctors in training to make the transition to the next stage of neurosurgical training, which was also identified in a Health Education Thames Valley visit report.

- 45 Supervisors and the education management team considered investment in specialist nurses would improve ward cover and alleviate workload pressures, but there has not been sufficient progress in this area to date. Supervisors we met noted that there had also been slow progress in improving the general nursing support in the department, but considered that there were problems beyond training in the department related to workload.
- 46 Additionally ST4+ doctors in training were unable to meet curricular requirements relating to spinal surgery as these surgeries tended to be undertaken in the Nuffield Orthopaedic Centre or in the private sector. The need to collaborate with other services to provide training opportunities should be included in the neurosurgery recovery plan.
- 47 Overall, we are confident that the problems faced by neurosurgery are understood by the senior management team. The recovery plan clearly sets out the issues and actions required and there has been important and welcome progress. Even so, the outstanding issues in the department are significant and we consider that accelerating the pace of change in the department is necessary. The recovery plan in neurosurgery should be implemented in full and the pace of implementation accelerated.

Requirement 4: Ensure there is adequate time to support education and training at the John Radcliffe Hospital and Nuffield Orthopaedic Centre

- 48 A frequent issue which arose during our visit and the documentation reviewed was time for teaching and training. While we were impressed by the commitment and enthusiasm for education and teaching demonstrated by almost everyone we met, we noted some considerable difficulties experienced by supervisors in delivering education and teaching. While this varied by level and by department, we noted similar issues recurring across both the John Radcliffe Hospital and Nuffield Orthopaedic Centre.

- 49** Many of the students we met stated that they received relatively little teaching in some placements at the Nuffield Orthopaedic Centre; we heard that students often felt 'in the way' in clinics and that the Nuffield Orthopaedic Centre was not as orientated towards teaching at undergraduate level as the John Radcliffe Hospital. This was confirmed by supervisors who reported difficulties in finding time to teach and gave examples of students being turned away from potential teaching opportunities as the service was too busy to accommodate them. Undergraduate supervisors we met at both the sites stated, however, that they had excellent support from the medical school in terms of the management of undergraduate teaching and in terms of training for trainers. Students at the John Radcliffe Hospital reported a uniformly positive experience of teaching. We did hear some examples of workload issues impacting on teaching although students we met stated that considerable effort was made by consultants to make time for educational opportunities. Their work in educating medical students was rarely formally recognised for the purposes of job planning and allocation of supporting professional activities.
- 50** We heard that there was better recognition of educational time for postgraduate training in job plans, with most supervisors we met having allocated time for their roles. Some clinical and educational supervisors and doctors in training stated that there were considerable pressures on time; clinical supervisors of GPSTs in particular stated they experienced difficulties in finding educational time. GPSTs do not have educational supervisors in secondary care and the Oxford University Hospitals NHS Trust policy is to allocate time for education in the job plans of educational supervisors and a named clinical supervisor in each department only, we recognise that clinical supervision will be provided on a day to day basis by all consultants but will be managed overall for departments by named clinical supervisors. Consideration will need to be given to the number of doctors in training for which each named clinical supervisor is responsible. This resulted in little direct educational support for GPSTs at the John Radcliffe Hospital and we heard additional reports of some clinical supervisors having minimal contact with GPSTs. We also heard ongoing difficulties with finding time for education in some surgical specialties, many of which the senior management team is aware of. However, we also acknowledge that there have been important improvements in the educational experience in some specialties such as neurosurgery.
- 51** We discussed the Oxford University Hospitals NHS Trust's plans for the approval and recognition of trainers. It plans to appoint a lead in each department as a named clinical supervisor with responsibility for inductions, supervision and handover for doctors in training in their department. This designated clinical supervisor would have allocated time for this role, but routine clinical supervision of doctors in training as they carry out routine work, would be delivered by other consultants without any recognised time in their job plan to do so.

52 There is considerable pressure on time for teaching in some training programmes. At undergraduate level, we saw a clear commitment to teaching and training from the education management and many of the supervisors we met. Despite this, it was clear that there is currently insufficient time available at the Nuffield Orthopaedic Centre allocated to undergraduate teaching; we also noted a lack of formal recognition of time for undergraduate teaching generally. Clinical and educational supervisors must have adequate time for their role in education and training, including formal recognition of their role in undergraduate teaching in job plans.

Requirement 5: Take steps to maximise training opportunities for doctors training in cardiac surgery

53 We investigated a number of long running issues in cardiothoracic surgery at the John Radcliffe Hospital. Cardiothoracic surgery training is delivered as part of a consortium with University Hospital Southampton NHS Foundation Trust. The training programme is divided between Oxford and Southampton with doctors in training generally rotating every two years. We heard that the partnership with Southampton was recently introduced but that Oxford University Hospitals NHS Trust considered it to be working well and that there were regular management meetings between the two departments. The cardiothoracic service at the John Radcliffe Hospital relies heavily on non-training, non-consultant grade doctors as well as doctors on the cardiothoracic surgery training programme. Cardiothoracic surgery achieved three below average results in the 2013 national training survey, which rose to four in 2014 (for overall satisfaction, adequate experience, workload and study leave, with the latter being new in 2014). We reviewed documentation produced by the local management team outlining the delivery and governance of education in this specialty which recognised many of the challenges to education and training in the department.

54 Doctors working in the department (both those in training and those who were non-training, non-consultant grades) told us that there was a high workload, and that service pressures made educational opportunities more difficult to access. We found there was a difficult balance to strike between the education and service demands on non-training doctors whose appointments were local but contracted to include a training component. Although many of these issues fell outside the scope of our visit there is an obligation upon employers to honour the terms of their contracts. Providing opportunities for doctors in training in theatre can result in theatre lists taking more time, and we heard that pressure to complete theatre lists and heavy workloads could result in educational opportunities being lost.

55 A further issue is the ability of doctors in specialty training to gain operative experience. Doctors in training we met stated that opportunities to carry out cardiac surgery were more limited at the John Radcliffe Hospital and they needed to consolidate and improve their experience in Southampton. We heard that the complexity of the caseload made it difficult for them to gain the operating experience

they needed. We heard that this compared unfavourably to Southampton where there was an appropriate balance of cases to support their level of training. Supervisors we met considered that the case mix was adequate for doctors in training to get experience required by their curriculum, but noted the level of complexity meant that there were not always opportunities to carry out a whole case. However, they noted that improvements to the rota had been enacted, and that further work to match each doctor in training to an appropriate mix and level of cases would be desirable.

- 56** We consider that there is much scope for improvement to operative experience for doctors training in cardiac surgery. We heard of attempts to achieve closer alignment between the rota and caseload so that each doctor has opportunities to operate at an appropriate level, which we support. Currently pressure to deliver service means some consultants do not take advantage of opportunities for training lists or to provide opportunities for doctors in training to undertake components of operations under supervision in line with their training needs, as is standard practice in other training programmes. However, some of the issues raised suggested that the mix of cases seen by the John Radcliffe Hospital may not always provide the best experience for doctors in ST3-4 level training, as the complexity of cases may limit opportunities to operate for these doctors. The education management team should consider how to further maximise opportunities for operative experience for doctors training in cardiac surgery.

Recommendations

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

Number	Paragraph in <i>Tomorrow's Doctors (TD)</i> / <i>The Trainee Doctor (TTD)</i>	Recommendations for the local education provider
1	TTD 5.2, 6.13, 6.39	The relevance of secondary care placements for GPSTs should be increased.
2	TTD 6.1, 8.6	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.

3	TTD 2.2	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.
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Recommendation 1: Increase the relevance of secondary care placements for GPSTs

- 57** We found some scope for improvement in the training provided for GPSTs in secondary care at the John Radcliffe Hospital and Nuffield Orthopaedic Centre. The GPSTs we spoke to identified a number of positive areas of their training and were extremely supportive of recent changes in some areas to improve their programme. However, opportunities were being missed to tailor their experience in secondary care to their future careers as general practitioners and to the general practice curriculum. We also reviewed documentation about the recent changes to the GPSTs' paediatrics placements at Horton Hospital which had resulted in substantial improvements to the experience of GPSTs, and explored if any practice from this site was transferable to the John Radcliffe Hospital and Nuffield Orthopaedic Centre.
- 58** GPSTs we met considered that limited steps had been taken to tailor the experience in some placements in John Radcliffe Hospital and Nuffield Orthopaedic Centre to the general practice curriculum. Those who had completed or were completing placements in obstetrics and gynaecology and orthopaedics considered that current arrangements of these services offered very few opportunities to gain GP relevant experience. They attributed this to being on a rota which did not differentiate them from doctors on other specialty training programmes. They also gave examples where the requirements of service orientated rotas made it difficult to take advantage of potential learning opportunities within their placements. The clinical supervisors we met confirmed that GPSTs were not generally differentiated from core and sometimes foundation trainees in each department.
- 59** The GPSTs we met also noted that clinical supervisors were often not familiar with the general practice curriculum and portfolio used for assessment, which was confirmed by the clinical supervisors. The GPSTs we met stated this could sometimes make it difficult to conduct supervised learning events for their portfolio and affected the quality of the feedback provided. Educational supervisors of GPSTs, who are local general practitioners, confirmed this and noted that the reports from clinical supervisors in secondary care could be variable, but with some specialties, such as psychiatry and rheumatology often completing reports to a high standard. We note that some of these issues are not straightforward, as access the portfolio can be complicated for clinical supervisors who are not general practitioners. However, it was clear that the level of engagement with the requirements of the general practice programme by clinical supervisors could be improved.

- 60** While we found some challenges, there were some positive aspects of GP training at the John Radcliffe Hospital. The GPSTs we met were enthusiastic about their experience in emergency admissions and geriatrics, and considered these placements provided valuable experience for their future careers as general practitioners. We also heard that the general practice placements in paediatrics had been modified to include a week of outpatient community paediatric and neonatal experience. The GPSTs we met were highly supportive of this and stated that the placement provided good experience. They also praised the paediatrics placements at the Horton, noting that the changes made to their supervision arrangements and the efforts to match their experience to the general practice curriculum had resulted in an excellent placement.
- 61** We explored some of the challenges with educational supervisors of GPSTs, the general practice training programme directors and the education management team at Oxford University Hospitals NHS Trust. Training programme directors we met noted that they had recently started a series of rolling meetings with departments hosting GPSTs and had adopted GPST job planning templates from another local education and training board with the intention that these plans would help tailor the experience of GPSTs in secondary care to the requirements of their training programme. These were recent innovations and we found limited awareness of these changes amongst clinical supervisors and GPSTs, even amongst departments where these meetings had already taken place.
- 62** Overall, we consider that there are opportunities to improve the relevance of the clinical experience of GPSTs in secondary care to the general practice curriculum, including improving the engagement of the clinical supervisors with the requirements of the general practice curriculum. While we accept there are some challenges posed by the management of the general practice portfolio and the nature of the curriculum, we consider there are opportunities for improvement. There is also a precedent for making improvements to general practice placements in the paediatrics placements at the Horton. The relevance to general practice of secondary care placements for GPSTs should be increased.

Recommendation 2: Improve online inductions, some specialty inductions and induction information for medical students

- 63** We found some variability in the quality of inductions for students and doctors in training at Oxford University Hospitals NHS Trust. Doctors training in some specialties reported a good experience of induction, supported by detailed and useful information, but this was not replicated in all departments. In advance of the visit, we reviewed documentation from Oxford University Hospitals NHS Trust (including the results of an audit of induction) and Health Education Thames Valley (for example, the annual trust report and the minutes of a meeting of directors of medical education across the region) and evidence from the national training survey all of which identified induction as a recurring issue, this was acknowledged by the

education management team. However, some of the material provided demonstrated projects to audit the quality of induction and plans for improved inductions in some specialties, which we explored on the visit.

- 64** We reviewed evidence suggesting there are longstanding problems with induction for doctors training in neurosurgery and cardiothoracic surgery. Neurosurgery is working towards a training recovery plan which suggests a number of improvements to induction. We were pleased to find that doctors training in neurosurgery reported a much improved experience of induction, and supervisors in the department were able to identify further areas they wanted to improve in the induction programme. A similar experience was reported by doctors working in cardiothoracic surgery who were similarly positive about their induction.
- 65** Foundation doctors we met were critical about the quality and usefulness of some departmental inductions, such as paediatric surgery. We also noted examples reported through regional directors of medical education meetings of departments in which inductions were being completed outside of working hours due to service demands, an experience borne out by some of the GPSTs we met. However, the foundation doctors we met were generally positive about the trust induction and confirmed they received information about raising concerns.
- 66** The major issue raised by both F1 and F2 doctors in relation to induction was to do with the technological aspects of induction, reporting it was difficult to get access to clinically necessary computer systems and difficulties in accessing technological support. Both F1 and F2 doctors we met also reported difficulties with accessing the online induction modules. This was also reflected in the experience of GPSTs we met, who stated they struggled to request clinical investigations and view the results of these, and could not gain access to some parts of the hospital with swipe cards in their first few weeks.
- 67** Students from Oxford Medical School we met also reported difficulties with accessing computer systems. We noted that students we met had not always received information on some clinical aspects of the system, such as how to raise an emergency call using the 'fast bleep' system. We heard an example where providing this information to students would have been useful in an emergency situation.
- 68** It was clear that variability in the quality of induction is a known issue and that action had been taken to monitor and improve some aspects, including through the foundation doctors forum. Many of those we spoke to, including foundation doctors referred to continual monitoring and auditing of induction so the technological problems we identified were known to the senior management team. The quality of induction, specifically the online components of induction, departmental induction in some specialties, and the information provided to medical students when starting placements should be improved.

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

- 69** The doctors in training we met were not universally receiving feedback about the incidents they raised or were involved in. Doctors in both years of the foundation programme had submitted online incident reports but none had received feedback. Doctors training in cardiothoracic surgery would raise any concerns about patient safety directly with their consultants rather than through the online reporting system. All doctors training in neurosurgery had submitted reports online but only one had received feedback but they were reassured that their consultants were made aware of incidents and would take action.
- 70** We did hear that the director of medical education reviews all reports of incidents involving a doctor in training. There is a designated administrator in the education centre who liaises with colleagues in clinical governance to identify incidents raised by or involving doctors in training. The director of medical education meets the administrator weekly to review these incidents. If a patient has come to any harm through the incident this is reported to Health Education Thames Valley as the postgraduate dean is the responsible officer for all doctors training in the region.
- 71** There is a formative learning and clinical practice form which is supposed to be sent to the doctor in training with a covering letter recommending they discuss the incident with their educational supervisor, who also receives a copy. None of the doctors in training we interviewed had received this letter, form, or met with their educational supervisor to discuss an incident. Serious incidents and near misses also inform simulation exercises for doctors in training.
- 72** Oxford University Hospitals NHS Trust should provide feedback on incidents to all doctors in training who report them or were involved in them. The process we heard of, running alongside clinical governance, sounds good and we encourage its further development. We do recognise that this is a new initiative and that we did not interview all doctors in training.

Acknowledgement

We would like to thank the John Radcliffe Hospital and Nuffield Orthopaedic Centre and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.