

Visit report on Plymouth Hospitals NHS Trust

This visit is part of the South West regional review to ensure organisations are complying with the standards and requirements as set out in [Promoting excellence: standards for medical education and training](#).

Summary

Education provider	Plymouth Hospitals NHS Trust
Site visited	Derriford Hospital
Programmes	<p>We met with individuals from the following programmes:</p> <p>Undergraduate: Plymouth University Peninsula Schools of Medicine and Dentistry (PU PSMD), Peninsula College of Medicine and Dentistry (PCMD).</p> <p>Postgraduate: foundation, core medical training (CMT), acute internal medicine, cardiology, emergency medicine, gastroenterology, respiratory medicine.</p>
Date of visit	9 May 2016

Areas working well

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

Number	Theme	Areas working well
1	Theme 1: Learning environment and culture (R1.1)	We found the culture at the Trust to be caring and compassionate with a positive learning environment for both learners and trainers. Trainers and supervisors are dedicated and

		committed to their educational roles. (See paragraphs 1-3)
2	Theme 2: Educational governance and leadership (R2.3)	Educational governance of medical student placements is effective. We heard about strong leadership from Plymouth and Peninsula medical schools. (See paragraph 54)
3	Theme 2: Educational governance and leadership (R2.3)	The review of doctors in training at regular consultant meetings promotes early recognition of concerns and need for support. (See paragraph 55)
4	Theme 3: Supporting learners (S3.1)	Most of the doctors in training and medical students we spoke with told us the Trust gives them appropriate support and that they would recommend the post. (See paragraph 72)
5	Theme 3: Supporting learners (R3.6)	We heard from doctors in foundation training that Peninsula graduates feel well prepared for F1. (See paragraph 76)
6	Theme 4: Supporting educators (R4.2)	The Trust values its educators. We heard that trainers have enough time in their job plans to meet their educational responsibilities. (See paragraph 88)
7	Theme 5: Developing and implementing curricula and assessments (R5.4)	Medical student placements at the Trust are delivering good coverage of the undergraduate curriculum. (See paragraphs 95-97)

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 1: Learning environment and culture (R1.12)	The Trust must ensure that its rotas are designed to allow doctors in training to meet the requirements of their curriculum and training programme. (See paragraphs 24-29)
2	Theme 1: Learning environment and culture (R1.14)	The Trust must review handover procedures between departments to ensure all handovers take place effectively and consistently to avoid any risk to patient care. (See paragraphs 35-38)
3	Theme 2: Educational governance and leadership (S2.1 & R2.1)	The Trust must make sure its educational governance systems and processes to control the quality of medical education and training are clearly understood by both educators and learners and must also demonstrate Board level oversight. (See paragraph 51)
4	Theme 2: Educational governance and leadership (S2.2 & R2.2)	The Trust must clearly demonstrate accountability for educational governance at board level and that educational and clinical governance are integrated effectively. (See paragraph 53)
5	Theme 5: Developing and implementing curricula and assessments (R5.9)	The Trust must ensure there is appropriate balance between providing service and accessing educational and training opportunities for doctors in training. This should allow for release for mandatory training sessions and outpatient clinics as required in the curriculum. (See paragraphs 102-105)

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 1: Learning environment and culture (R1.7)	The Trust should ensure that workload does not adversely affect the time available for educational activities and supervision of doctors in training. (See paragraph 16)
2	Theme 1: Learning environment and culture (R1.13)	The Trust should review its induction procedures and practices to ensure consistency of experience across departments. (See paragraphs 30-34)
3	Theme 1: Learning environment and culture (R1.17 & R1.19)	The Trust should ensure that they monitor and manage any adverse impact that non-training grades and other healthcare professionals, such as physician associates, may have on the education of doctors in training and medical students. (See paragraphs 41-43 and paragraph 47)
4	Theme 3: Supporting learners (R3.7)	The Trust should work to ensure that doctors in training receive their rotas in a more timely fashion. (See paragraph 78)

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' where things are working particularly well or where there is a risk that standards may not be met.

Theme 1: Learning environment and culture

Standards

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

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

Raising concerns (R1.1)

- 1** We found that the culture at the Trust allows learners and educators openly to raise concerns about patient safety. The students and doctors in training whom we met said they knew how to raise concerns and feel supported in doing so. We heard about an informal monthly meeting for doctors in training to raise any items, which the Medical Director or another member of the senior team attends. The educational and clinical supervisors told us they run safety days where they discuss patient safety issues that have been handled well and those that have been handled less well with doctors in training.
- 2** PU PSMD students were confident that their feedback is taken on board and changes are made as a result. There are feedback forms readily available at the Faculty office, or they can share any items with representatives on the medical students committee. Some of the PU PSMD students mentioned that although they are confident that changes do take place as a result of their feedback, sometimes they can be slow.
- 3** Foundation doctors and Year 5 PCMD students informed us that they learn about how to raise concerns during induction. Foundation doctors mentioned that when they have raised concerns they are listened to but suggested that the Trust could be better at closing the feedback loop, as sometimes the person who raised the concern is not told about the outcome. Doctors training in core medical training (CMT) would approach their educational and clinical supervisor to raise any concerns, and those training in emergency medicine have 'a consultant of the day' as the contact point for any concerns.

Area working well 1: We found the culture at the Trust to be caring and compassionate with a positive learning environment for both learners and trainers. Trainers and supervisors are dedicated and committed to their educational roles.

Dealing with concerns (R1.2)

- 4** The Trust has in place a clear policy on raising concerns about patient safety. PU PSMD students were given cards which explain the process clearly. Educational and clinical supervisors informed us that they are comfortable raising concerns about patient safety and would be proactive in seeking feedback about the concern they raised.
- 5** CMT doctors in training gave us an example of the Trust taking action on a concern they raised about handover. Rotas were revised to ensure rest days for doctors in CMT were on Tuesdays rather than Mondays thereby ensuring a safer handover could take place following the weekend shifts.
- 6** We heard that although concerns are dealt with within individual departments, there was not much evidence of the learning from these changes being implemented Trust wide.

Learning from mistakes (R1.3)

- 7** PU PSMD's process for identifying concerns involves the school undertaking an audit of student feedback and then grouping the feedback into areas for improvement, for example by theme such as patient safety or for a particular department at the hospital. The students we spoke to from PU PSMD confirmed that the medical school encourages feedback at the end of placements.
- 8** The students gave us examples of action being taken on two particular concerns they raised: inconsistencies in the timetable for cardiology were addressed, and changes were made to the diagnostic week so that students were given more information beforehand about post mortems. The students tend to feed back directly to the medical school rather than to the Trust, and the medical school then liaises with the Trust as needed.

Supporting duty of candour (R1.4)

- 9** We heard that there is an open and honest culture at the Trust and duty of candour is well evidenced. Educational and clinical supervisors told us about regular governance meetings where duty of candour is discussed. Doctors in higher specialty training were encouraged to get involved with handling complaints.
- 10** All the groups we spoke to had awareness about their duty of candour. There is no formal teaching on duty of candour but they are directed to the GMC's guidance. PCMD students were able to describe it in detail. PU PSMD students had the

opportunity to discuss it with peers in small groups. Doctors in higher specialty training told us they have had informal teaching about it and that duty of candour is mentioned on incident forms. Foundation doctors gave an example where one of the consultants working in care of the elderly mentioned duty of candour and being open and honest with a patient's daughter to explain what happened with the care of her mother.

Seeking and responding to feedback (R1.5)

- 11** Twelve safety concerns were raised in the 2015 GMC survey, but reduced to three in 2016. Senior management told us about a change programme that was launched in August last year to address the growing number of patients for elective procedures. They reassured us that continuous improvement happens on the wards and input from doctors in training is sought. They regularly seek feedback both formally and informally from doctors in training to monitor how any changes are working. The Trust appeared to rely heavily on the medical school for student feedback and the GMC's national training survey for trainee feedback.
- 12** PU PSMD students cited two examples where changes had occurred following feedback. Firstly, there had been a problem in the cardiology department with medical students arriving not having been expected. This feedback was given at the end of the first term and during the second term the problem was fixed. Secondly, PU PSMD students currently do not have any interaction with grand rounds. A survey was carried out in December 2015 on the medical students' perception of grand rounds and changes were made as a result. Feedback has been addressed by the medical school and although nothing can be done for current Year 3 students, the grand rounds are going to be timetabled differently next year.
- 13** PCMD students were confident that feedback to the school was triangulated with the Trust. They told us about a meeting at the end of each six week block with the consultant which was a way of providing feedback. The students described senior clinicians as very open to discussing concerns. They mentioned that the induction day at the beginning of pathways was introduced due to student feedback.
- 14** Foundation doctors suggested that the Trust could do better at closing the feedback loop in terms of communicating what happened to the concern they had raised. They said that sometimes there was an absence of output when concerns are raised, even though it seemed they were listened to at the time.
- 15** Higher specialty trainees spoke about the open culture at the Trust and that they are asked to support junior doctors and pick up any concerns. Doctors in higher specialty training explained that feedback often occurs through informal meetings with trainee groups within the Trust and across the region on training days. They provide both positive and negative feedback via the departmental leads.

Appropriate capacity for clinical supervision (R1.7)

- 16** We were concerned when we heard about a doctor in foundation training working without supervision on the Hartel ward in care of the elderly (COTE) for a period as long as eight weeks. We were told there are recruitment issues in the specialty so there was no lead consultant at the time, but there is now a consultant and a senior registrar on the ward so the situation has improved. Other doctors training in COTE reported a good experience and assured us that the problem with supervision on the Hartel ward has been rectified. We would expect this to be sustained. We were informed that there are eight consultant posts on COTE but only four are actually filled. It means that sometimes there is no consultant ward round over the weekend across the service for COTE, which we viewed with concern.
- 17** Foundation doctors said there is good support both during the day and at night and described staff as supportive despite the high workload. Doctors in higher training were pleased with the level of specialty experience and the opportunities available. They also highlighted strong support from seniors despite difficulties with rota gaps.

Recommendation 1: The Trust should ensure that workload does not adversely affect the time available for educational activities and supervision of doctors in training

Appropriate level of clinical supervision (R1.8)

- 18** Consultants provide a high quality of supervision and support to trainees and students. PU PSMD students raised no concerns around supervision, and were confident that their supervisors have a good understanding of the curriculum.
- 19** PCMD students said that sometimes consultants offer them the opportunity to learn extra skills but they are never pressurised to do so. If students assist in theatre, they are always supported by the registrar or consultant. On ward rounds there is always a doctor in training to review their work. PCMD students commended emergency medicine, where they are given assessment dates and guidance on what they need to do towards completing their assessments. The medical assessment unit (MAU) was named as being particularly well supported with a high consultant presence.
- 20** Foundation doctors suggested that there may be scope for more targeted supervision as they do not always get the opportunity to work with their consultant supervisor. There was a general sense that time for supervision is very pressured.
- 21** We were pleased to hear there is 1:1 supervision from a consultant for doctors training in CMT. In contrast, higher specialty trainees said that sometimes they can go for 12 hours on the wards without seeing a consultant. Like the students, doctors in higher specialty training cited emergency medicine as a department providing excellent clinical support. They also told us there is always a consultant present in cardiology. In gastroenterology, we heard about tension with the general internal

medicine workload impacting on time for supervision and experience within the specialty.

Appropriate responsibilities for patient care (R1.9)

- 22** Doctors in training across all levels assured us they are not asked to carry out any procedures outside their competency. They were very clear that were they to be asked to undertake a procedure they were not comfortable with, they would feel confident raising it. We heard about one of the PU PSMD students inserting a cannula before undertaking the relevant clinical competency but they were supervised for this and said that it did not feel unsafe.

Identifying learners at different stages (R1.10)

- 23** During the visit, the doctors in training and staff we met at the Trust occasionally used the terms 'senior house officer', 'SHO' and registrar. They had a common understanding that 'SHO' can include doctors in second year of foundation training (F2), doctors in the first and second years of core training (CT1, CT2), and doctors in the first two years of run-through specialty training (ST1, ST2). The term 'senior house officer' or 'SHO' is ambiguous for doctors in training, members of the multidisciplinary team, and patients, as it does not specify the level of training of the individual doctors. Both consultants and doctors in training commented that this did not result in trainees being asked to work beyond their competence as they were clear about the different grades and competence levels. We noted that it did not say 'SHO' on the doctors' badges where their level of training was explicit.

Rota design (R1.12)

- 24** Almost all doctors in training and trainers that we met highlighted the heavy workload across departments and specialties. The increasing volume of patients and number of outliers were a constant challenge at the Trust. Doctors in training informed us that one of the main problems is rota gaps which exacerbate workload issues and directly affect the balance between service provision and training. Doctors in training are not always assigned to a rota on the basis of their training needs, but primarily to provide the service. They were often moved between departments in order to plug gaps in the service provision.
- 25** The acute medical rota was highlighted as a particular challenge that often impacted on the training experience in other medical specialties, in particular gastroenterology. Measures have been taken to address the medical registrar rota so the F2s are not asked to act up to address gaps in rotas.
- 26** Senior management informed us that rotas have improved over the last 18 months and they are compliant with the Working Time Regulations (WTR). Doctors in training told us there is compliance with WTR officially, but that unofficially this was not the

case. Some trainees have been asked to do extra hours but as a locum so that it complies with WTR.

- 27** We were told that the hours in emergency medicine were very good and that the duration of the shifts stays to time. In contrast, respiratory medicine contained very long shifts with some trainees listed on the rota for 91 hours in a week or listed as working 13 days running. CMT doctors in training explained that rotas in acute medicine changed a lot at short notice and it would not take much for the rotas to fall apart. Cover at weekends was described as too thin, with no contingencies for absence.
- 28** Doctors in higher specialty training told us about the lack of registrars in cardiology – there are 6.5 when they need 10. The additional work this requires in the department is very dependent on goodwill but it cuts into training time. Some doctors in training commented that they did not mind doing a 24 hour shift in cardiology because they do not get called very often at night.
- 29** Educational and clinical supervisors confirmed that the rotas are designed to ensure patient safety, but whilst they are good for continuity of care they are not good for continuity of training. Doctors in training and consultants are often pulled in to the general medical take. Sometimes CMT doctors are used to act as middle grade doctors. The medical registrar rota fragments their ability to train because ward continuity is very poor due to doctors in training constantly being moved. They told us that trainees can feel vulnerable at night and they questioned only having one registrar on the rota.

Requirement 1: The Trust must ensure that its rotas are designed to allow doctors in training to meet the requirements of their curriculum and training programme.

Induction (R1.13)

- 30** The Trust induction has scope for improvement. In addition, departmental inductions were reported to be of varying quality. Senior management explained that the Trust makes sure that everyone has an induction through the *Intrepid* system.
- 31** PU PSMD students told us there have been times when there has been no departmental induction and they are taken on ward rounds straight away without receiving one. When there is a dedicated person whose responsibilities include induction, it makes a difference and is much more likely to take place. PCMD students spoke well of the Trust induction. There is a full week of induction in Year 5, and Years 3 and 4 have an induction at the start of each week, usually with a more senior doctor.
- 32** Foundation doctors explained that most of the induction is delivered online and they are expected to complete it in their own time. There are three different websites for induction with a lot of overlap. There is a module on equality and diversity in their

induction. When asked about departmental inductions, we were told there is a good induction for emergency medicine but the induction to MAU could be improved. If they miss the departmental induction then it's up to them to arrange another one.

- 33** CMT doctors found departmental induction good but thought Trust-wide induction was poor. The Trust induction was 90% online and they found a lot of the content irrelevant. They were not familiar with the Trust's systems even after completing the induction.
- 34** Doctors in higher specialty training generally took the view that the Trust-wide induction was necessary but too long. They also confirmed there is training on equality and diversity during induction. They were expected to do a lot of e-learning modules which were time consuming and were often completed during lunch or before or after work. They highlighted that the departmental inductions in emergency medicine and cardiology were good.

Recommendation 2: The Trust should review its induction procedures and practices to ensure consistency of experience across departments.

Handover (R1.14)

- 35** The effectiveness of handover varied across different departments, and in particular when patients are transferred from one ward to another. We remain concerned about the interface between different departments at the hospital and found that the current system poses a risk to patient safety; patients will be moved from wards unexpectedly with no handover. Senior management acknowledged the problem with patients moving between departments and assured us that they are working on a solution.
- 36** Senior management told us the priority with handover was ensuring continuity of care for patients. Educational and clinical supervisors highlighted handover as an educational opportunity in addition to the priority of ensuring patient safety. They monitor how doctors in training experience handover through the GMC survey and end of placement feedback.
- 37** There is an online system called e-handover but doctors in training reported it was not reliable, even though MAU doctors spent some time completing the e-handovers. There was not a clear understanding of the e-handover system and this had a negative impact on the care and wellbeing of patients moved between wards. Educational and clinical supervisors confirmed to us that the e-handover system is not working for MAU.
- 38** CMT doctors told us that improvements to handover had been made in the cardiology department. There is a dedicated handover day on Mondays to ensure continuity of care following the weekend. For the medical take, there is the same system across weekdays and weekends but it tends to work better at weekends. They also found

handover for patients moving between wards was problematic and confirmed that usually there is no handover for patients arriving from the MAU.

Requirement 2: The Trust must review handover procedures between departments to ensure all handovers take place effectively and consistently to avoid any risk to patient care.

Educational value (R1.15)

- 39** Senior management informed us that the hospital receives over 1000 referrals above capacity. Derriford has the second largest cardiovascular unit in the country. The large number of patients provides a wide variety of training opportunities and a wide range of practical experience to doctors in training.
- 40** CMT doctors in training said they do not receive much feedback on their performance unless something goes wrong. Doctors in higher specialty training explained that although consultants do their best to provide feedback, there usually is not enough time to review their performance after the take due to the sheer volume of patients. Feedback on their performance was mainly through the e-portfolio. We heard about the good quality of feedback in the gastroenterology department where there is the opportunity to talk through areas for improvement.

Multiprofessional teamwork and learning (R1.17)

- 41** Whilst we heard that inclusion of physician associates in the workforce was mostly beneficial, the impact on educational capacity should be considered. Clinical and educational supervisors said they did not feel equipped to take on physician associates. In their view, there was no real funding for it and the infrastructure was not in place yet. Although they supported the idea of physician associates to help with workforce and workload issues, there was little capacity to give them adequate experience whilst on placements.
- 42** Medical students were also aware of the tension in educational capacity due to the training provision for physician associates. They told us they have not had much interaction with them and wanted to learn more about what they do and which tasks they would be responsible for. There is not much interdisciplinary interaction and no joint teaching. We heard about tension in MAU where medical students thought that physician associates had more access to ward rounds than they did.
- 43** Foundation doctors also reported a lack of clarity and desire to learn more about the role of physician associates. CMT doctors in training supported the introduction of physician associates to help address workload issues.

Capacity, resources and facilities (R1.19)

- 44** Senior management mentioned the tension between secondary and tertiary care which causes tension between service delivery and training. They informed us that work is underway to improve the patient pathways in the hospital. The Trust recently employed several more doctors' assistants, and in conjunction with the medical school are training physician associates who are due to start working at Derriford in January-February 2017.
- 45** Derriford has been in extreme situations over the last year where the hospital has been put on red and black alerts but even in these severe situations, training is rarely directly affected. It has to be escalated to the Medical Director if measures need to be put in place that affect training, and this is a rare occurrence.
- 46** We heard that there were good educational facilities available at the hospital, such as the library and IT resources. Foundation doctors told us there is good e-portfolio support from the postgraduate centre, which helps them to achieve their learning outcomes.
- 47** Supervisors, clinical skills staff and teachers indicated their capacity to deliver education is stretched as it is a challenge to supply teaching and experience across a wide range of learners: medical students, doctors in training and physician associates. It is easier to achieve in larger departments where there are more patients and supervisors.

Recommendation 3: The Trust should ensure that they monitor and manage any adverse impact that non-training grades and other healthcare professionals, such as physician associates, may have on the education of doctors in training and medical students.

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

- 48** The senior management team considered human factor training and simulation as one of their strengths. CMT doctors confirmed that technology enhanced learning is good at this hospital but they do not get much access to it in CMT and would like access to improve. Higher specialty doctors in training told us that simulation is used a lot in emergency medicine and cardiology. It has proved particularly useful for resuscitation training.
- 49** PU PSMD students told us they use simulation facilities at the medical school rather than at the hospital and that it is used more frequently in the fourth year. They felt they had better access to simulation training than their peers at other medical schools. PCMD students had been invited to an F1 simulation session in emergency medicine. They also mentioned a simulation based course that takes place in Year 5.

Supporting improvement (R1.22)

50 The Trust is supporting learners to undertake activities that drive improvement in education and training. Doctors in higher specialty training confirmed they are encouraged to be involved in audits and are well supported for projects by the consultants.

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)

51 We found that the Trust's educational governance systems and processes are not clearly understood. In our meeting with the senior management team, we asked the Trust to provide us with details of its educational governance and quality management structures. The Trust referred us to meetings that take place but the visit team could not see clear evidence that education is discussed at this group. It was therefore difficult to understand clearly the educational governance systems and processes used to identify and monitor concerns about the quality of medical education and training at the Trust.

52 Doctors in higher specialty training praised the good relationship between departments and specialties at the hospital. We also heard in our meeting with education management about the introduction of quality panels at the Trust, which focus on education and training. We understand that quality panels are an initiative driven by Health Education England South West (HEE SW).

Requirement 3: The Trust must make sure its educational governance systems and processes to control the quality of medical education and training are clearly understood by both educators and learners and must also demonstrate Board level oversight.

Accountability for quality (R2.2)

53 In our meeting with the senior management team, we asked how education is discussed and represented at board level. The Trust told us about their risk register, a performance board report, discussions with the consultant body about any specific issues that arise and an awareness of wider issues going on in the region. We reviewed the minutes from board meetings and the subject of medical education was not on the agenda and did not appear to feature at the meetings. Clinical and educational governance at the Trust does not appear to be fully integrated.

Requirement 4: The Trust must clearly demonstrate accountability for educational governance at board level and that educational and clinical governance are integrated effectively.

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

54 Education management at the Trust told us there are lay members on quality panels and there are plans to add students to the panels from September 2016; they will receive training for this role. We heard that the disaggregation of PCMD was well managed and PCMD students assured us that the emergence of the new Plymouth Medical School had not impacted negatively on the quality of their education.

Area working well 2: Educational governance of medical student placements is effective. We heard about strong leadership from Plymouth and Peninsula medical schools.

55 Clinical and educational supervisors spoke to us about monitoring progression of doctors in training. In emergency medicine and acute medicine, there is a weekly consultant business meeting in which they discuss each doctor in training, both in approved training posts and non-training grades, to look at how they are progressing. It was described as a constructive meeting and a mechanism for identifying doctors in difficulty.

Area working well 3: The review of doctors in training at regular consultant meetings promotes early recognition of concerns and need for support.

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

56 There is scope to improve the Trust's collection of data generally and their use of equality and diversity data in particular to monitor progression and ensure the delivery of training is fair.

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

57 We found effective clinical and educational governance systems for PU PSMD and PCMD clinical placements. We heard about joint meetings between the Trust and medical schools. For example, representatives from the medical schools sit on and participate in the Trust board.

58 The teaching has changed very little since the disaggregation of the medical schools. Students from both cohorts did not find that their teaching had been affected by working alongside another School: each School uses their own supervisors and a considerable amount of work has been undertaken to avoid the risk of 'double teach'. The disaggregation of PCMD has influenced research and there is a bigger focus on clinical research by Plymouth Medical School and less of a focus on basic science.

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

- 59** Medical students had confidence that communication channels with the schools are open and that the schools have a strong relationship with the Trust. PCMD students told us about a feedback forum at the end of each term where they meet with clinical Deans. It was described as an open forum to discuss both positive and negative points about placements and also to provide feedback on their supervisors.
- 60** We heard about different mechanisms through which both good practice and concerns about the quality of postgraduate education and training could be raised: doctors in training could approach consultants or the education manager; audits take place; meetings across service lines; multi-disciplinary meetings on a weekly basis in which practice is discussed; and an example of feedback to Trust management occurred through a risk summit called by the consultants last year. Clinical and educational supervisors mentioned the challenges of financial pressures and external pressures preventing some of the issues experienced at the Trust being resolved.

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

- 61** Senior management told us that the hospital works closely with HEE SW and has a good relationship with the medical school. There is formal engagement with HEE SW through a regular contract meeting where the main focus is on their quality register and the GMC survey results. We were also told that the Director of Medical Education attends the regional Dean's education group, which meets once a month. There is also a lot of informal contact through emails and phone calls, particularly around doctors in difficulty. The Trust described the lines of communication between the hospital and HEE SW as very open, facilitated by the inclusion of the Chief Executive on the board at HEE SW. There were no recommendations from senior management on what HEE SW could be doing better and the relationship was described as working effectively.
- 62** With regards to quality management between the Trust, medical schools and HEE SW, we were told that the Trust sends a questionnaire to the students about their placements; they also visit the clinical area and speak to the tutors. The Sub Dean at PU PSMD holds a dual role as deputy director at the Trust. Education management told us about a meeting between HEE SW and Trust staff that contributes towards the quality management of undergraduate education. There is also an exchange of information between the School and the Trust.

Monitoring resources including teaching time in job plans (R2.10)

- 63** Senior management informed us that they allocate supporting professional activities (SPA) time in job plans for all educational and clinical supervisors. However, they recognised that there is a widespread issue with trainers not being able to fully utilise their SPA time due to service challenges. This view was supported by the supervisors

who confirmed that they do get time for education in their job plans, but they struggle to use the time allocated because of service pressures.

- 64** Senior management advised us that the Trust has reconfigured the remuneration for supervision and redistributed it to create postgraduate education leads.

Clinical supervisors for doctors in training (R2.14)

- 65** The education management team told us about a survey sent to F1s to check if any of them have been left without supervision. Foundation doctors told the Trust they had been asked to move across wards too frequently. As a result, a guideline was put in place to limit the number of times F1s could be moved across wards.

Educational supervisors for doctors in training (R2.15)

- 66** We heard from PCMD students that there is dedicated time for educational supervision in each pathway week.
- 67** CMT doctors in training found exposure to clinical and educational supervisors was variable. We heard that supervisors would judge the competency of doctors in training well in person, but were less likely to transfer information to trainees' e-portfolios.
- 68** Doctors in higher specialty training said that they are allocated an educational supervisor soon after starting their training at the Trust and are encouraged to meet with them. They felt well supported by their educational supervisors. One of the respiratory trainees commended their educational supervisor in particular because of how well they supported the trainee in working less than full time.
- 69** Education management told us that the provision of educational supervision is valued by the Trust. Time for supervision is looked at during the appraisal process and the Trust monitors how often clinical and educational supervisors meet with their trainees.

Managing concerns about a learner (R2.16)

- 70** Most doctors in training and clinical and educational supervisors approach the education manager for support with any concerns or difficulties. Education management told us there are effective ways of identifying doctors in difficulty. For example, some are referred to HEE SW for additional support but often they just need individualised training or pastoral support. If doctors in training are having problems in one placement then consideration is taken as to whether they could be moved to a different placement in the region.

Compliance with legislation (R2.19)

- 71** We heard from medical students about robust training on equality and diversity delivered by the medical school.

Theme 3: Supporting learners

Standard

S3.1 *Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and achieve the learning outcomes required by their curriculum.*

Good Medical Practice and ethical concerns (R3.1)

72 Medical students mentioned there is good contact with the Faculty office. The majority of PU PSMD and PCMD students, foundation, CMT and higher specialty doctors in training are enjoying their placements. They would recommend working at Derriford and most would be happy to return for placements in future. We heard about a very supportive environment at the hospital that is friendly and senior colleagues are approachable. MAU was named as the department which delivered the least amount of learning because of service pressures.

Area working well 4: Most of the doctors in training and medical students we spoke with told us the Trust gives them appropriate support and that they would recommend the post.

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

73 PCMD students commended the medical school for providing such strong pastoral support during their placements. They would be comfortable approaching the school about any issues.

74 We heard from foundation doctors that they are allocated a mentor by HEE SW. CMT doctors in training told us about the careers team at the Trust who were described as very helpful, for example they can arrange mock interviews. They also cited the consultants as a useful resource for careers advice.

Undermining and bullying (R3.3)

75 PU PSMD and PCMD students, CMT and higher specialty doctors did not have any concerns about bullying or undermining and did not perceive it as an issue at the hospital.

Student assistantships and shadowing (R3.6)

76 We heard how effective the PCMD course is in preparing students for the foundation programme. Seven of the foundation doctors we spoke to had graduated from PCMD. They told us they spent most of their fifth year on the wards. Current PCMD students confirmed the focus on preparing for foundation training. They complete their finals in their fourth year so that fifth year assessments are based on competencies needed for F1. However, one student commented that they have not come across the same diversity of patients as they would in places like London.

Area working well 5: We heard from doctors in foundation training that Peninsula graduates feel well prepared for F1.

Information about curriculum, assessment and clinical placements (R3.7)

77 PCMD students said they are not always told in advance what they will be covering on placement and that it varies between specialties. The students we spoke to confirmed none of them felt underprepared for their placement. They suggested that some initial information to guide students as to the timing of outpatient clinics would be useful.

78 Doctors in training, particularly in gastroenterology, informed us they are not receiving their rotas in advance of starting their rotations, which makes annual leave difficult. The experience in cardiology specialty training was variable but because staff in the department knew each other very well, they received a lot of information on an informal basis.

Recommendation 4: The Trust should work to ensure that doctors in training receive their rotas in a more timely fashion.

Information and support about academic opportunities (R3.8)

79 There are academic tutors based at Derriford to support doctors in training. Medical students were comfortable approaching the tutors.

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

80 Doctors in higher specialty training working less than full time reported no problems in this area and found the Trust to be fully supportive.

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

81 We came across one doctor in higher specialty training who returned to training following a career break. They reported no problems in this area and found the Trust to be supportive.

Study leave (R3.12)

82 Doctors in training informed us they are able to take study leave but it was within the limitation of rotas. They are able to access 30 days study leave, consisting of 15 days internal and 15 days external.

Support for learners in difficulties (R3.14)

83 Clinical and educational supervisors told us about the support available for doctors in difficulty, with resources available through HEE SW and occupational health. There

would be a team approach in supporting the doctor in difficulty, providing them with individually tailored support, depending on the issue. They gave examples of doctors in training being provided with more supervision and coaching, not being expected to undertake night duty and referred for additional specialist support if required.

Career support and advice (R3.16)

84 As mentioned under 3.2

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)

- 85** The educational and clinical supervisors told us they are well supported by the Trust and were enthusiastic about their roles as a result. We heard that their educational responsibilities are reviewed as part of their formal appraisals.
- 86** They explained there is an induction and ongoing training package for clinical and educational supervisors. HEE SW has introduced compulsory training modules; there are seven requirements and some of the modules contain equality and diversity, dealing with doctors in difficulty and training on the Annual Review of Competence Progression (ARCP). The training modules also include information on supervision time in job plans, how to balance rotas and how to seek feedback from doctors in training. We heard there are also specialty specific training sessions available, which have topics based around the curriculum requirements for a particular specialty.
- 87** It is mandatory to attend 60% of the training days. For educational and clinical supervisors to be released for these courses, they often need to rebalance time in job plans and coordinate rotas. The consensus from the group we spoke to is that the courses are worthwhile.

Time in job plans (R4.2)

- 88** We heard in our meeting with education management that there is a robust system for allocating time for supervision in job plans. The Director of Medical Education (DME) has made sure there is a dedicated PA for both clinical supervision and educational supervision. Clinical and educational supervisors confirmed they had real and adequate provision for education and training in their job plans. However, we heard about high workloads impacting on their educational roles and that it is challenging to access their allocated hours for medical education. Clinical and educational supervisors told us that now there is better management of the in-patient care workload, which has freed up more time for supervision.

Area working well 6: The Trust values its educators. We heard that trainers have enough time in their job plans to meet their educational responsibilities.

Accessible resources for educators (R4.3)

89 However, clinical and educational supervisors were frustrated by the lack of staff, and said that the hospital is not as pleasant a place to work as it was eight or nine years ago because of the significant increase in patient numbers. There is a high calibre of doctors in training at the hospital but it is getting harder to train them due to the service requirements. They mentioned in particular the deficit in care of the elderly (COTE), which only has four consultants when they thought there should be 10-12 consultants for such a large hospital. They explained that resources are pulled from the medical take in order to sustain COTE.

Educators' concerns or difficulties (R4.4)

90 The DME told us that he feels completely supported in his role and that education and training is taken very seriously at the Trust. Clinical and educational supervisors told us that they can voice their concerns and feel listened to. The supervisors told us that their main concerns were around the volume of patients and recruitment of doctors in training, but acknowledged these are challenges across the region. They were aware that improvements to workforce have occurred over the last year due to additional financial support.

Working with other educators (R4.5)

91 Education management gave us examples of ways educators liaise with each other to make sure there is a consistent approach to education and training. Each specialty has a School which delivers clinical training for tutors within the Trust. Some of the schools hold events in their specialty for clinical and educational supervisors. The foundation school delivers an annual update on any changes happening in foundation training.

92 Medical school assessments and specialty curricula assessments are often prescribed, which helps trainers to ascertain what to assess for learners in different stages of medical education and training. Clinical and educational supervisors told us that most of their doctors in training have positive ARCP outcomes, which indicates they are providing effective education and training.

Recognition of approval of educators (R4.6)

93 Education management informed us that trainers are up to date with their training. There is consistency with training for clinical and educational supervisors across the region. We heard there has not yet been correspondence from HEE SW on whether the trainers at the Trust are on the approved list of trainers.

Theme 5: Developing and implementing curricula and assessments

Standard

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

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

Undergraduate curricular design (R5.3)

94 We heard about the patient population in the South West generally not being from diverse social, cultural and ethnic backgrounds. Medical students have had talks on equality and diversity and we were informed about a social integration week at the School. They would feel comfortable raising any queries on equality and diversity with the hospital and School. They said there are often teaching opportunities in outpatient clinics when they are able to discuss how to interact appropriately with different patient groups.

Undergraduate clinical placements (R5.4)

95 Year 3 PU PSMD students found the structure of their placements was well organised. They were provided with a manual containing links for the pathway week and bullet points on what experience they should be gaining from the placement. The type and quality of the information in the manual varied depending on the placement. Although they were given learning objectives for every pathway week, they were rarely assessed to check whether the learning objectives were being met. Emergency medicine and MAU were highlighted as particularly good departments for reviewing the achievement of the defined learning objectives.

96 Year 3 PU PSMD students commented that there is good exposure to patients at Derriford but they did not receive enough practical experience, such as cannulations or taking blood. They did not spend much time with the junior doctors but tended to shadow consultants. They suggested that having guidelines from the medical school on how many bloods they should be taking would be helpful. They commented that having more targeted learning objectives would boost the level of their practical experience.

97 Years 4 and 5 PCMD students were confident they are able to meet curricular requirements. They had acquired clinical skills across most of the major specialties, and explained that learning in a large acute Trust ensured a breadth of exposure and experience. They thought the best placements were the return weeks, special study units (SSUs) or placements that are longer in duration. Year 5 requires more self-directed learning as there is less scheduled teaching. They explained that in Year 5 they are involved in grand rounds and can attend F1 teaching.

Area working well 7: Medical student placements at the Trust are delivering good coverage of the undergraduate curriculum.

Assessing GMC outcomes for graduates (R5.5)

98 Year 3 PU PSMD students explained that although they are not assessed on the wards, assessments take place during clinical skills building. There are clinical reasoning sessions every week which are protected teaching time.

Fair, reliable and valid assessments (R5.6)

99 Medical students were not always clear on how a final judgement of professionalism is derived and how individual professionalism judgements contribute to the overall assessment framework. Professionalism judgements appeared to be subjective to the consultant supervising them and were variable as a result. The students were not convinced that all of the consultants supervising them were knowledgeable about professionalism judgements.

100 Medical students acknowledged that positive on-the-spot judgements were a mechanism for recognising good performance by students. They asked for more guidance for on-the-spot judgements and what behaviours generate positive or negative judgements. Their impression was that negative on-the-spot judgements were fed back to the medical school more quickly than positive judgements.

Mapping assessments against curricula (R5.7)

101 PCMD students commented on the clear guidance they are given about integrated structured clinical examinations (ISCEs) and students are also supplied with the marking criteria.

Training programme delivery (R5.9)

102 There is an imbalance between providing service and accessing educational and training opportunities for doctors in foundation training. We heard that rotas are designed around service delivery and not around training needs, and that access to teaching for these doctors is being compromised. Meeting curricular requirements was often self-directed by doctors in training. There is no teaching run by HEE SW but there is teaching organised by the Trust.

103 The F1s and F2s raised concerns that sometimes there appears to be miscommunication from the rota managers that teaching sessions are cancelled when actually they have been taking place, and this has led to doctors in training missing them. Foundation doctors also spoke to us about difficulty in getting workplace based assessments (WPBA) signed off as a lot of their time is spent clerking patients and the consultants are very busy coping with a heavy workload.

104 CMT doctors in training spoke positively about outpatient clinic experience in respiratory medicine because there are timetabled slots, even though the department is very short staffed. Doctors training in CMT said that opportunities for education and learning vary between departments. Cardiology was one of the few departments at the hospital where there is bleep-free teaching. Teaching for CMT consists of a full day once a month. The teaching days are built in to the rota so they are not expected to work on those days. There have been occasions when they have not been released because they are needed for service cover in the hospital. When they are released for teaching they have found the sessions useful.

105 The balance between service and training for doctors in higher training was better but we did hear some concerns of a similar nature. There were no concerns about the teaching in cardiology, which occurred on a weekly basis, and teaching in emergency medicine was also praised by doctors in higher specialty training. Education management were aware that service pressures were impacting on training opportunities, particularly in MAU.

Requirement 5: The Trust must ensure there is appropriate balance between providing service and accessing educational and training opportunities for doctors in training. This should allow for release for mandatory training sessions and outpatient clinics as required in the curriculum.

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GMC staff	Emily Saldanha (Education Quality Assurance Manager) Lucy Llewellyn (Education Quality Analyst)
Evidence base	<ul style="list-style-type: none"> ■ Organisational chart for postgraduate medical education (January 2016) ■ Medical education post list – people within postgraduate medical education (January 2016) ■ Job description for service line education lead (November 2014) ■ Minutes of medical education committee (September 2015) ■ Minutes of medical education committee (December 2015) ■ Quality governance – Trust assessment of compliance with quality standards (January 2016) ■ Minutes of annual contract meeting with HEE SW (December 2014) ■ Pre-meeting summary for contract meeting with HEE SW (January 2016) ■ Minutes of Trust / medical school meeting (June 2015) ■ Minutes of Trust / medical school meeting (October 2015) ■ Assessment of compliance with education and training standards (September 2015) ■ Derriford quality register submitted to HEE SW (October 2015)

- Trust risk management policy (January 2016 draft)
- Trust equality and diversity policy (November 2012)
- Doctors in difficulty policy (January 2014)
- Trust incident management policy (April 2015)
- Trust serious incident management policy (April 2015)
- Agenda and minutes of Trust Board meeting (July 2015)
- Agenda for Trust Board meeting (January 2016)
- Job plans overview 2015-2016
- Description of handover: acute internal medicine, cardiology, emergency medicine, gastroenterology, respiratory medicine.
- Trust induction documents and specialty induction documents for: acute internal medicine, cardiology, emergency medicine, gastroenterology, respiratory medicine.
- Documents on trainee support