

Visit Report on University Hospitals of Leicester NHS Trust

This visit is part of the East Midlands regional review.

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

Summary

Education provider	University Hospitals of Leicester NHS Trust
Sites visited	Leicester Royal Infirmary
Programmes	Foundation, core medical training, anaesthetics, acute internal medicine, cardiology, gastroenterology and general internal medicine.
Date of visit	25 October 2016
Overview	<p>University Hospitals of Leicester NHS Trust is a large acute teaching trust consisting of three hospitals; Leicester General, Glenfield and Royal Infirmary. The visit took place at the Royal Infirmary site although we did hear from doctors training at Leicester General and in Glenfield as well. The trust provides placements for medical students from University of Leicester Medical School. The trust is known internationally for their specialist treatment and services in cardio-respiratory diseases, renal and cancer disorders. The heart centre is located at Glenfield.</p> <p>The emergency medicine department at the trust was being monitored via the GMC enhanced monitoring process. However in 2016, the GMC and Health Education East Midlands local office deemed the significant improvements made to this department as sustainable and the case was closed. In the latest Care Quality Commission visit, the</p>

Trust was graded as 'requires improvement'. The Trust work closely with University of Leicester Medical School and De Montfort University to provide multiprofessional training for nurses, doctors and healthcare professionals.*

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

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. These should be shared with others and/or developed further.

Number	Theme	Good practice
1	Theme two (R2.1, R2.2)	<p>The trust is clearly committed to education and training with defined, transparent educational governance systems and structures in place as well as a strong educational team. The Trust displays clear accountability for educational governance at a trust board and directorate level which includes the engagement of the lead non-executive director for education and patient partners to improve the quality of education.</p> <p>See paragraph 44 & 45</p>

Areas that are working well

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

Number	Theme	Areas that are working well
1	Theme one (R1.3)	<p>The trust demonstrates a culture that enables doctors in training to learn from mistakes and reflect on incidents and near misses through a variety of measures such as bulletins posted on the intranet and via email and regular mortality and morbidity meetings.</p> <p>See paragraph 4</p>
2	Theme one (R1.10)	<p>The trust has a good, reliable system in place using coloured lanyards to identify the doctors in training at different stages of education and training which helps staff understand their level of capability and competency.</p>

		See paragraph 12
3	Theme one (R1.14)	<p>The 'pulse check' is a highly praised initiative which doctors in training say is valuable to discuss minor issues occurring on the wards. We urge the trust to continue to roll this out across the different departments in the trust.</p> <p>See paragraph 29</p>
4	Theme one (R1.15)	<p>The clinical experience week where doctors in training, particularly core doctors in medical training attend clinics all week works well. This shows the trust's commitment to education and enables doctors in training to meet the requirements of their curriculum.</p> <p>See paragraph 33</p>
5	Theme one (R1.20)	<p>The clinical skills unit with high quality simulation facilitators ensures that students and doctors in training get the opportunity to develop their clinical, medical and practical skills through technology enhanced facilities. The team leading the unit were particularly valued by the learners we met.</p> <p>See paragraph 40</p>

Requirements

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

- targeted
- outlines which part of the standard is not being met
- mapped to evidence gathered during the visit.

We will monitor each organisation's response and will expect evidence that progress is being made.

Number	Theme	Requirements
1	Theme one (R1.13)	<p>The trust must ensure that all doctors training in the different specialties receive an appropriate induction before starting their on-call duties.</p> <p>See paragraph 22</p>
2	Theme one (R1.14)	<p>The trust must ensure that they organise handover of care at night in cardiology to provide a continuity of care for patients and maximise the learning opportunities for doctors in training.</p> <p>See paragraph 30</p>
3	Theme one (R1.19)	<p>The trust must ensure that doctors in training do not have to share their login details or leave computers logged on for other users to reduce the risk to patient safety.</p> <p>See paragraph 37</p>
4	Theme three (R3.3)	<p>The trust must ensure that they have appropriate systems in place to collect feedback from learners on undermining and harassment. They must also ensure that any undermining and bullying issues are addressed in a timely manner.</p> <p>See paragraph 65</p>
5	Theme five (R5.9)	<p>The trust must ensure that all core doctors in training are given sufficient experience to achieve and maintain the clinical and medical competencies required by the curriculum.</p> <p>See paragraph 93</p>
6	Theme five (R5.9)	<p>The trust must ensure that all doctors in the second year of foundation training are able to</p>

		<p>fulfil the requirements of their curriculum and attend required teaching sessions.</p> <p>See paragraph 94</p>
7	Theme five (R5.12)	<p>The trust must ensure that all staff understand the importance of making reasonable adjustments for medical students when needed and when to take appropriate action to accommodate adjustments to assessments.</p> <p>See paragraph 97</p>

Recommendations

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

Number	Theme	Recommendations
1	Theme one (R1.19)	<p>In two of the three hospitals in the trust, there is a lack of sufficient work and social space to meet learners' needs. The trust should consider how to provide learners with suitable accommodation to enable learners to work more effectively whilst in the hospitals.</p> <p>See paragraph 36</p>
2	Theme five (R5.4)	<p>The trust should consider how they teach and deliver the undergraduate curriculum as currently their implementation lacks the coherence and structure it needs to ensure students value their learning experiences in the Leicester hospitals.</p> <p>See paragraph 88</p>

Findings

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

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

Theme 1: Learning environment and culture

Standards

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 During induction, doctors in training are advised about the various ways that they can raise a concern and the importance of doing so. They can raise concerns by telling a consultant in their department, using the Gripes tool or via the Datix system. Doctors in training we met felt the length of time it took to complete a Datix meant they used it only for serious incidents and not for low level concerns. Managers also told us about the 3636 helpline, another mechanism at the Trust which doctors in training can use to raise concerns.
- 2 The Gripes tool was created in-house at the Trust in response to feedback from doctors in training about the need for a mechanism to report low level concerns. Some of the doctors in training that we met felt the Gripes tool was an excellent way for them to relay their concerns. However doctors in training did say the small number of computers and limited work spaces at the trust made it difficult to use the Gripes tool and Datix as efficiently as they would like.

Dealing with concerns (R1.2)

- 3 Doctors training in acute medicine told us about the top ten tips handbook they receive at induction which is based on any patient safety issues or incidents that have occurred previously. They found that this was a helpful guide in understanding how concerns are dealt with. However, the majority of doctors in training we met do not feel that they get sufficient feedback on any patient safety issues that have been raised. They told us that the lack of response via the Datix system meant they did not know the result of their concern and did not receive specific feedback about the

outcome of the issue they had raised, although, as stated below, feedback is disseminated in other ways.

Learning from mistakes (R1.3)

- 4 Doctors in training stated that there are a number of methods at the trust which enables them to learn from mistakes and reflect on incidents and near misses in an open way. For example, they receive bulletins about never events and they receive feedback on relevant incidents during their ward rounds. The trust also conduct regular mortality and morbidity meetings to disseminate lessons learnt from incidents. Foundation doctors told us that they attend these mortality and morbidity meetings as part of their general teaching and learning.

Area working well 1: The trust demonstrates a culture that enables doctors in training to learn from mistakes and reflect on incidents and near misses through a variety of measures such as bulletins posted on the intranet and via email and regular mortality and morbidity meetings.

Supporting duty of candour (R1.4)

- 5 Doctors in training learn about the duty of candour during induction. Core doctors in training told us that they are encouraged by consultants to take the lead by being open and honest with patients and their families when something goes wrong. This helps them to develop the skills they need to communicate with patients in a tactful and empathetic manner.

Appropriate level of clinical supervision (R1.8)

- 6 Foundation doctors we met commented that there is always a doctor at a higher level to supervise and consult when needed. They did feel that the higher doctors in training were very busy but this did not deter from them offering an appropriate level of support. In cardiology, foundation doctors said the wards were busy but they were always supervised and felt safe.
- 7 Core doctors in training also agreed that the level of clinical supervision they receive is appropriate and ensures that they do not work beyond their competence. They felt consultants were available to discuss cases. They stated that the critical care unit is particularly well protected and supervised. The majority of doctors in higher training told us that they found the consultants at the trust both approachable and supportive. They said they received particularly close supervision for very sick patients.
- 8 Noticeably, prior to the visit there was feedback from doctors in training in the national training survey (NTS 2016) which suggested clinical supervision out of hours

at the trust was not sufficient. However during the visit, we found an evident improvement. Higher doctors in training felt that the out of hours supervision they received was appropriate for their needs, level and requirements. On acute medicine wards for example, there are two consultants on site overnight with one on-call and available by phone. During the weekend, there is a gastroenterology consultant on site during the daytime and tasks are co-ordinated through the nerve centre. They found it helpful that seriously ill patients are automatically flagged to the on-call middle grade doctor which ensures closer supervision.

- 9 In cardiology, senior managers state that they have found it difficult to ensure that doctors training in this speciality are sufficiently supervised clinically. HEE EM stated their concerns in the Deans Report and brought in external specialists to conduct a review. Since then, the trust have worked closely with HEE EM to appoint new consultants, especially in cardiology, to support doctors in training where there are issues with gaps in rotas and supervision.
- 10 The clinical supervisors we met told us that they have received appropriate training to ensure that they offer the right amount of support and supervision for doctors in training for whom they are responsible.
- 11 Clinical supervisors also said there is a tension between service and training particularly in specialties like cardiology. This means clinical supervisors do find it difficult to consistently fulfil their roles such as reviewing doctors in training's clinical and educational practice throughout their placement. The trust does employ clinical teaching fellows who work with phase two students.

Identifying learners at different stages (R1.10)

- 12 The trust uses colour coded lanyards to identify doctors at different stages of their training. This is helpful for all staff members to understand the level of any individual doctor in training and to ensure that doctors in training are not expected to work beyond their competence. Doctors in training told us that they appreciate this and think it is a useful method. There are currently no specific lanyards for medical students at the trust. We would encourage the trust to expand this method of identifying learners to medical students when on placements at the Trust.

Area working well 2: The trust has a good, reliable system in place using coloured lanyards to identify the doctors in training at different stages of education and training which helps staff understand their level of capability and competency.

- 13 During the visit, doctors in training and staff at the Trust used the terms 'senior house officer', 'SHO' and 'registrar'. They had a common understanding that 'SHO' can include doctors in their second year of foundation training (F2), doctors in the first and second years of core medical training, and doctors in the first few years of specialty training. However, the use of lanyards has helped mitigate the risk of

members of the multidisciplinary team being unclear about the level of training of individual doctors.

Rota design (R1.12)

- 14** At the beginning of the visit, senior managers told us that they have taken a number of measures to ensure that education and training is treated as importantly as service delivery. This includes the recruitment of trust grade doctors to alleviate service pressures for doctors in training. As a consequence, there is more flexibility in regard to rota design and more opportunity for the education and training of doctors. Senior managers are also developing international links with Malta and India to attract doctors to work at the Trust. This in combination with the recruitment of physician associates and advanced nurse practitioners has also helped with the design of the rota ensuring time for training.
- 15** Senior managers also told us that they have recruited junior department administrators to organise the rotas. In cardiology, there is a medical staffing manager who designs the rota. They believe that this has led to improvements in the balance between education, training and service. Senior managers use workforce planning meetings to ensure that rotas are designed appropriately and to recognise where there are rota gaps. Initiatives such as the clinic week are embedded in the rotas and rotas are overseen by the human resources department. Senior managers did comment that their junior department administrators do have to deal with emerging rota gaps on a daily basis.
- 16** Prior to the measures outlined above, foundation doctors told us that at its worst, they were only able to attend 40% of local teaching sessions and often had to come in on their days off to try to meet their training requirements. They found that doctors in training were always cross-covering wards due to the design of the rotas and the gaps in rota. Foundation doctors told us that there was a great deal of service provision requirements that have disrupted their training and they reported this to consultants. The majority of foundation doctors we spoke to during the visit commented that they have seen improvements in the rota design since senior managers have taken the action described above.
- 17** Core doctors in training were not getting enough time in clinics but the measures that have been taken by senior managers thus far has ensured that now clinics are accessible and well attended. Furthermore, in cardiology, there is a great demand for service which was affecting the quality of training. However, senior managers told us that doctors in training are now getting a lot more support in regard to their access to training. Foundation doctors training in cardiology told us that the rota has been altered so that Fridays are always free for them to access local teaching. Furthermore, cardiology rota gaps are now being covered adequately.
- 18** In gastroenterology, doctors in training told us that, due to the busy service on the wards, it was difficult to get enough time and opportunities to train. They commented

that the number of consultants in the department was constantly changing too and they had to contribute to the acute on call rota which was detracting from their specialist experience. However, the trust has now designed a specific rota for gastroenterology to enable doctors training in this specialty to access key educational opportunities. Doctors training in gastroenterology told us that this has led to some improvement but it is still early to judge the full extent of this.

- 19** The trainers we spoke to commented that over the last few years, the trust have managed to find a good balance so that now they have bleep free training sessions for doctors in training and consultants are paid for extra time on units such as the intensive care unit to help deliver educational opportunities. In anaesthetics, there used to be many gaps which was very concerning because doctors in training were used to fill these, interrupting their training. However the trust has invested in recruiting extra consultants to give doctors in training the freedom to go to training sessions.

Induction (R1.13)

- 20** In the NTS results from 2015, doctors in training gave negative feedback for the quality of induction. The feedback improved in the NTS 2016 results. During the visit, we confirmed that the trust induction has indeed improved. Health Education East Midlands local office (HEE EM) have supported a new e-induction to ensure all new doctors in training have the same overall induction covering subjects like equality and diversity, patient safety and manual handling. Learners are advised to complete this training prior to starting their placement at the trust. Many learners told us that the e-induction was satisfactory and enabled them to learn about key subjects. For the majority of doctors in training, they received a day in lieu for completing the induction prior to the commencement of their placement. Doctors training in cardiology were unaware of this possibility.
- 21** Core doctors in training told us that they found the trust induction was good. They found it particularly useful to have one place to sort out issues such as their log in details for the different IT systems. They commented that departmental induction was appropriate although they were not always able to attend. They said if they were allocated to start on nights on the rota, there was no opportunity to get another induction. Core doctors in training we met said they would like more structured information from their department induction about how to handover patients. For example in gastroenterology and acute medicine, they receive a handbook about handover which doctors in training found extremely useful. Doctors training in other specialties said they would like something similar.
- 22** Foundation doctors in training told us that they do find their induction quite chaotic as the trust try to induct so many of them at the same time. They found a lot of the information could have been sent to them via email a few weeks before they started. For foundation doctors starting on nights, they found induction did not prepare them adequately. For example, they could not prescribe and did not know where to go to

collect the on-call bleep. Therefore, foundation doctors felt induction did not provide them with sufficient information regarding organisational issues. Foundation year one doctors did appreciate the shadowing opportunity that a majority of them received prior to starting their placements at the trust.

Requirement 1: The trust must ensure that all doctors training in the different specialties receive an appropriate induction before starting their on-call duties.

- 23** Senior managers told us that the challenges they have currently with induction is ensuring doctors in training moving between trusts access the correct information when starting at University Hospitals of Leicester NHS Trust. Doctors in training also said although the actual induction has improved, the administration systems can be a problem. For example when transferring to the trust from another hospital within the East Midlands, payroll can sometimes get their pay and tax wrong which takes some time to sort out and can be quite stressful. Senior managers also told us that they are working with HEE EM to try to establish an East Midlands passport which will contain information such as the immunisations a doctor in training has been given. The passport can then be transferred with the student and will contain all the vital information a trust needs. This will help to alleviate some of the problems identified moving doctors in training between trusts.
- 24** Initially, in order to complete a department induction, all doctors in training at the same level had to attend at the same time and this meant taking clinical staff off the wards. Now, induction has been streamlined appropriately and they rotate departmental induction to ensure that doctors in training can provide some continuity of service.
- 25** Some medical students did say that they feel induction information is sent to them at the last minute. As a consequence, they may be placed at the trust and get little information about their placement beforehand. Furthermore, students told us that when they arrive at the trust, they might not be expected and the block leads do not seem to know about their impending arrival in advance. Hence, their first week at the trust can be quite chaotic.

Handover (R1.14)

- 26** Each of the specialties we visited had a different handover system which ensured the continuity of care for their patients. Doctors training in higher medical specialties felt that handovers have improved a great deal. The departments have recently introduced a more structured handover process which has helped eliminate any patient safety issues. This system involves coordinators who guide the handover meetings and ensure that the team attends punctually. Doctors in higher training did say that for some of them who enjoyed leading the handover, having a coordinator meant they did not lead as much. However overall, they agreed that the structure and support the coordinators brought to handover was positive.

- 27** In anaesthetics, doctors in training told us that they do not use nerve centre (a handover system); all of their handovers are done face to face. Furthermore, in the intensive care unit, again, all handovers are face to face and there is a consultant present.
- 28** Foundation doctors outlined that they find handovers very clear and organised. At Glenfield for example, handover takes place in both the morning and evening and consultants are present at these meetings. Nerve centre is used mainly in acute medicine so there is a record for those not present during the face to face handover meeting.
- 29** In some departments, we heard about the 'pulse check' which is a catch up meeting that takes place at 3am. This gives doctors in training, consultants and the multiprofessional team a chance to check how work is, how busy the wards are, how work can be distributed, and to discuss minor issues. Doctors in training state that they can miss the pulse check only if there are emergencies.

Area working well 3: The 'pulse check' is a highly praised initiative which doctors in training say is valuable to discuss minor issues occurring on the wards. We urge the trust to continue to roll this out across the different departments in the trust.

- 30** Handover in cardiology was considered not to be as effective. Higher doctors training in cardiology are sometimes unable to attend handover due to the way the rotas have been organised. At times it is possible for higher doctors training in cardiology to cover three different areas simultaneously and therefore they cannot attend handover meetings especially when they occur at the same time in every department. Furthermore, at night, in the coronary care unit, there can sometimes be one higher doctor in training covering two wards with no consultant present so, therefore, their attendance at handover is variable. Due to the busy nature of the unit and the unpredictability at night, handover can be chaotic. In the day however, the doctors in training say the ward is consultant led and handover is a smoother process.

Requirement 2: The trust must ensure that they organise handover of care at night in cardiology to provide a continuity of care for patients and maximise the learning opportunities for doctors in training.

- 31** The trainers we spoke to felt that handover was a good learning opportunity for doctors in training especially for those in higher training who sometimes got to lead handover. Senior managers say they have installed the nerve centre system which has helped formalise handover across the hospital. Doctors in training told us the daily schedules the trust distribute has clear handover protocols attached to it which guides all staff on best practice.

Educational value (R1.15)

- 32** Generally, doctors training in University Hospitals of Leicester felt their experiences were of educational value. Foundation doctors in particular were able to clerk many patients and they felt there was always a more senior member of staff present to support them and offer advice when needed. In surgery, foundation doctors training at Leicester General did comment that they rarely got sufficient time in theatre and they expected more exposure to surgical procedures. On the other hand, foundation doctors at Glenfield said the teaching and experience at this site is excellent.
- 33** The trust runs a clinical experience week which enables doctors in training to attend clinics all week. This was looked on favourably by both trainers and doctors in training because it enabled all doctors in training involved to gain valuable clinical experience. Furthermore, it enabled doctors in training to meet the requirements of their curriculum which was particularly useful for core doctors in medical training. Core doctors in medical training told us that they were particularly pleased with the bleep free environment which they experienced during the clinical experience week.

Area working well 4: The clinical experience week where doctors in training, particularly core doctors in medical training attend clinics all week works well. This shows the trust's commitment to education and enables doctors in training to meet the requirements of their curriculum.

Protected time for learning (R1.16)

- 34** Some doctors in higher training told us that they have teaching on Fridays and this is generally well attended. In anaesthetics and intensive care for example, doctors in training said the quality of teaching was very good and these sessions were always well attended. Occasionally due to business on the wards or other commitments, the attendance of doctors in training could be affected. Service pressure restricting access to teaching was most problematic in general internal medicine; doctors in training are expected to attend 70% as a requirement for a satisfactory Annual Review of Competence Progression (ARCP) but the current level of gaps in the middle grade rota prevented this. Many of the teaching sessions are available on line. However doctors in training reported that work pressure limited their ability to make full use of this facility.

Capacity, resources and facilities (R1.19)

- 35** We heard that there are not sufficient office and work spaces for doctors in training at University Hospitals of Leicester NHS Trust. Both foundation and core doctors in training commented on the lack of areas in which to have confidential phone conversations with patients or a space in which to conduct handover meetings.
- 36** Doctors in training and students commented that there is a lack of sufficient social spaces for them to interact and converse. They also do not have access to any

lockers to store away their private items. This complaint was most prevalent amongst doctors training primarily at Royal Infirmary or Leicester General. There were areas in Glenfield with similar issues but overall, this site seemed to have more space for doctors in training to socialise and work.

Recommendation 1: In two of the three hospitals in the trust, there is a lack of sufficient work and social space to meet learners' needs. The trust should consider how to provide learners with suitable accommodation to enable learners to work more effectively whilst in the hospitals.

- 37** Doctors in training raised issues about the information technology facilities at the trust. The number and range of IT systems at the trust is causing a risk to patient safety. They expressed frustration at the numerous systems they have to use on a daily basis which require different logins. Also, some systems are very old and slow. This causes doctors in training to share their logins as it takes each user so long to log onto the systems. To circumvent this doctors in training are leaving computers logged on and risking information breach. We heard that doctors in training share login details when prescribing, which makes it unclear who has issued a prescription. Senior managers at the trust assured us that the IT system is being redesigned and it will ensure there is a single log on mechanism which will be introduced in the next few months.

Requirement 3: The trust must ensure that doctors in training do not have to share their login details or leave computers logged on for other users to reduce the risk to patient safety.

- 38** Prior to the regional review visit, information in the HEE EM Deans Report for the region relayed concerns about the library facilities at the trust. We were pleased to see the improvements made to learning resources in response to learners' concerns. The library facilities at the trust are excellent. Over the past few years, the trust has made many improvements to the library to ensure it meets the needs of all learners.

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

- 39** Foundation doctors told us that the simulation facilities at the trust are of a good standard. However they also commented that they do not get enough time engaging with simulation based learning.
- 40** Students really enjoy using the clinical skills unit as they say there is a high standard of equipment available to use and the staff are extremely helpful and knowledgeable.

Area working well 5: The clinical skills unit with high quality simulation facilitators ensures that students and doctors in training get the opportunity to develop their clinical, medical and practical skills through technology enhanced facilities. The team leading the unit were particularly valued by the learners we met.

Access to educational supervision (R1.21)

41 Doctors in training stated that they were able to access their educational supervisors easily when they were nearby or located at the same trust. They found it more difficult when their educational supervisor was at a different hospital or trust as they often had to arrange meetings during their days off and in some instances, this required lengthy journeys.

Supporting improvement (R1.22)

42 We heard about a number of quality improvement projects learners have been involved in at the trust. For example, core doctors in training told us about the work they had done with higher doctors in training to create a system to improve the quality of handover on the wards. Overall, doctors in training said that after the completion of this project and the implementation of the suggested changes, they have seen a noticeable improvement in the quality and frequency of handover generally at the trust. Doctors in training and their trainers told us that although there are areas where further development in regard to handover is required, the improvements so far have been good.

Theme 2: Education governance and leadership

Standards

S2.1 *The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.*

S2.2 *The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.*

S2.3 *The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.*

Quality manage/control systems and processes (R2.1); Accountability for quality (R2.2)

- 43** The trust has effective, clearly understood, educational governance systems and processes to manage the quality of education. The trust takes a systematic approach to the management of education using the analysis of dashboards to define key indicators for the state of education and training throughout the trust. Educational leads in particular use the dashboard to assess quantitative measures such as the frequency of education activity and learners' attendance. The executive workforce board is chaired by the chief executive at the trust and this is where action plans for each directorate are reviewed. The director of medical education presents a paper to the board quarterly. At this meeting the director of medical education told us they get plenty of opportunity to discuss education and training with the board. Following the meeting, the director of education then works with the team to fulfil any actions encouraged by the board.
- 44** The trust has identified a non-executive director for education at the trust. The role of the non-executive director is to ask the 'tough' questions regarding the education and training of doctors to ensure patient safety remains central to all trust decisions. The non-executive director told us that they also try to ensure that the education on offer at Leicester is value for money. They state that they work closely with the patient partner lead at the trust to ensure that all concerns are relayed to clinical managers and the patient voice is heard at all levels of the trust including in education.
- 45** There is a clear accountability for educational governance at the trust at board level. The trust board regularly discuss medical education and training during their senior meetings.

Good practice 1: The trust is clearly committed to education and training with defined, transparent educational governance systems and structures in place as well as a strong educational team. The Trust displays clear accountability for educational governance at a trust board and directorate level which includes the engagement of

the lead non-executive director for education and patient partners to improve the quality of education.

- 46** Senior managers state that they are working hard on internal quality processes to try to be more proactive in identifying and dealing with issues at the trust. They state that the use of education quality dashboards has helped the education leads become less reliant on information from the NTS and therefore they can identify issues occurring in a department early. Issues can be escalated to the board to be discussed at their quality meetings. This approach has enabled a number of services with educational difficulties to be improved. Senior managers state the most dramatic improvement has been seen in the running of the emergency department which has been improved with the support of HEE EM. The emergency department was monitored under the GMC enhanced monitoring process but due to the improvements made, it was removed from this process in 2016. Furthermore, work is still ongoing at the Glenfield site to improve working conditions and already the changes are apparent through the positive feedback they are starting to get from staff and learners. A majority of core doctors in training we met during the visit whose training is based at the Glenfield site were positive about their placements and did state that things have been improving. Some of these improvements include the fact there is now a fully staffed rota in place; the recruitment of trust grade doctors to alleviate the service pressures on doctors in training and the fact there is now no more than a certain number of clinics assigned to each doctor in training.
- 47** The trust work closely with Leicester Medical School meeting regularly in their clinical management group. Senior managers work with HEE EM on different projects such as the redistribution of placements in the region.
- 48** Senior managers state that they feel HEE EM support them very well. They find HEE EM's quality visits (both trigger and their annual quality visits) are helpful. They find that the reports from these visits do help inform and drive the quality agenda at the trust. Using their internal quality processes, senior managers told us that they sometimes identify issues prior to HEE EM instigating a trigger visit. The DME, Department of Clinical Education Team and CMG Education Leads meet to discuss the quality in their departments looking at the dashboards and their NTS results. They then action plan appropriately based on this.

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

- 49** The trust does consider the impact on learners of policies, systems and processes by gaining their views. For example, doctors training in medicine reported to the trust that they found the use of the nerve centre for handover unhelpful and felt that a few of the ward rounds were difficult due to this. As a consequence, conditions were changed based on the learners' feedback and doctors in training appreciated this.

- 50** The clinical and educational supervisors we met said they always try to create a space for doctors in training to raise any sensitive issues they may have but this is not always possible due to the lack of sufficient office space. They feel that there are a number of methods at the trust for doctors in training to share their feedback and raise any concerns they may have.

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

- 51** Senior managers at the trust told us that they collate a lot of information about learners' performance, progression and outcomes. They use this information to inform how best to deliver the curriculum and to identify any adjustments that need to be made to the delivery of training. Senior managers we met state that they also collate data on equality and diversity and use this information to ensure they meet the needs of all of their learners including making reasonable adjustments where needed. As part of their work, senior managers told us they looked at the ethnic backgrounds of their patient population, the doctors in training and the supervisors and compared this data to identify where there are notable differences. So far, they have not made any changes to their practice in light of this information.
- 52** The trust has recently employed a new role called the Clinical Management Group (CMG) Education Lead. Their role is to work closely with the education team to help produce the dashboards which is the system the trust use to collate all of their data in one place. Undergraduate block leads also use this information. The trust conducts in-house surveys; use results from the NTS, and information derived from soft intelligence such as meetings with supervisors and the junior doctor forum to inform their dashboards.

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

- 53** Senior managers at the trust told us that they work closely with HEE EM and Leicester Medical School to monitor the quality on placements. There are clear systems and processes in place at HEE EM, Leicester Medical School and University Hospitals of Leicester NHS Trust to ensure the monitoring of quality happens consistently. For example, both the school and HEE EM conduct quality visits to the trust to ensure a suitable quality of training and education for undergraduates and postgraduates. Furthermore, we heard that the trust work closely with HEE EM to look at ways that they can make improvements to training programme delivery. When the trust or HEE EM identify a department is in difficulty in regard to training, they work closely together to try and improve conditions.

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

- 54** We heard from supervisors that they do find it difficult to fulfil their roles in the allocated time in their job plans. This has led to supervisors occasionally delivering extra hours outside of the time identified for education in their job plans as non-core supporting professional activity (SPA). Senior managers state they have done a lot of

work to ensure adequate time in job plans for educational needs and this is starting to have a positive impact.

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

- 55** To ensure a safe environment and culture for all, the trust run a project to support the trust grade doctors they recruit. This project includes seminars on subjects such as an introduction to the NHS and separate training support mechanisms for trust grade doctors to access. This support is specific to the needs of trust grade doctors and is organised at a time that is appropriate for them. The trust ensures this support is different from the support given to doctors in training. Trust grade doctors can access simulation training which helps address the needs of those that have gained their primary medical qualification internationally.

Educators for medical students (R2.13)

- 56** At the trust, the medical school have block leads who coordinate the training of medical students, supervise their activities and ensure that they are meeting the requirements of the curriculum. They ensure assessments map directly to the curriculum. Block leads also work closely with the medical school to ensure students are gaining the experience needed at the trust to inform their educational progression.
- 57** The educators are working with the medical school to develop a mentorship scheme for students based at the trust. The mentors are consultants or associate specialists who have undergone training and the programme is being rolled out currently. The students we spoke to are looking forward to engaging with the mentorship programme.

Educational supervisors for doctors in training (R2.15)

- 58** All doctors in training we met told us that they have access to an educational supervisor. Foundation and core doctors in training told us that they could be placed at a different site from their educational supervisor. This means in order to meet their educational supervisor, they have to travel some distance. As a consequence, foundation and core doctors in training told us they organise meetings on their day off or before their shift begins to enable them to travel to see their supervisor.
- 59** All higher doctors in training have an educational supervisor who they have met formally at least once. For those who are located near to their educational supervisor, they state that they meet regularly informally and find that they can get support from their supervisor very easily.

Sharing information of learners between organisations (R2.17)

- 60** Senior managers at the trust assured us that they regularly share information about learners with different organisations. The trust work closely with the medical school to ensure they get timely and accurate information about the students who undertake a placement at one of their hospital sites. This includes information about reasonable adjustments for students where relevant. The trust also work with HEE EM to ensure they share information about doctors in training especially when it concerns a fitness to practise, safety or wellbeing concern. Senior managers said they depend on the information from HEE EM in regard to any disability or less than full time training requests.

Theme 3: Supporting learners

Standard

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

Good Medical Practice and ethical concerns (R3.1)

61 Doctors in training and students we met told us that they have been advised to read Good Medical Practice. Students received teaching on Good Medical Practice and they commented that it was a very helpful guide when they wanted to raise ethical concerns at the trust.

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

62 Learners commented that if they have an issue, in the first instance they will speak to their supervisors. They also stated that they could go to their training programme or foundation programme director. If the issue was of a personal nature, then doctors in training told us that they could be referred to occupational health where appropriate. All learners that we met said their supervisors are very approachable and they would feel comfortable to discuss any issues with them including those about their mental health.

Undermining and bullying (R3.3)

63 Prior to the visit, we found reports of a culture of doctors in training feeling inhibited to report any bullying and undermining concerns. Senior managers told us that they take undermining and bullying very seriously and have a clear process they follow when dealing with any reported incidents. They state that they act on concerns promptly and encourage doctors in training to report any issues as early as possible either to their supervisor or a trusted member of the department. The trust state that they work closely with HEE EM when they need to deal with any major cases of bullying or undermining. Furthermore, educators told us that they act as supervisors and personal tutors and support their learners in this way.

64 However some of the doctors in training we met during the visit told us that on the wards, they sometimes experience undermining and bullying particularly from other medical professionals and senior consultants. In some instances, the reported issues were dealt with promptly and an agreeable solution was decided for the doctors in training involved.

65 Some students we met told us that they had experienced comments from consultants advising certain careers due to their gender or ethnic background and belittling certain career choices in comparison to others. For example, female students were

advised not to follow certain surgical careers due to their lack of physical strength or their need to have a family which would distract them.

Requirement 4: The trust must ensure that they have appropriate systems in place to collect feedback from learners on undermining and harassment. They must also ensure that any undermining and bullying issues are addressed in a timely manner.

Information on reasonable adjustments (R3.4)

- 66** The information provided to learners about reasonable adjustments is variable. Most of the information provided about reasonable adjustments is given to learners during induction including details on where and how to access support when needed. Doctors in training stated that service has taken priority in many ways which means support for reasonable adjustments is not as consistent as expected.

Student assistantships and shadowing (R3.6)

- 67** We heard from all foundation doctors that they had completed assistantships and they found these very useful. After electives, final year students do a four week block shadowing experience which will be increasing to eighteen weeks in the future with the planned curriculum reform. Foundation doctors told us they generally feel well prepared but the degree to how prepared they felt was dependent on which medical school they attended.

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

- 68** All core and higher doctors in training were happy with the information they receive on assessments and the curriculum. They stated that their educational supervisors provide good guidance and check to ensure that they are completing the required work based assessments. Core doctors in training were happy that in their induction, their assessments were signposted very well with clear information given on what is expected of them.
- 69** At foundation level, doctors in training were not as pleased about the quality of information they receive on curriculum, assessment and their clinical placements. Some foundation doctors stated that they did not receive a meeting on assessments whereas others stated that there was a meeting provided but the information given was not sufficient to meet their needs. Some foundation doctors told us that they received written information about their assessments in their induction pack.

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

- 70** Doctors in less than full-time training commented that they feel very well supported by the trust. Reasonable adjustments are made to the rotas to accommodate their training needs and their Training Programme Directors are very helpful. Some doctors

in training did say 'keep in touch days' (that are accessible to those on maternity leave) are not well advertised.

Study leave (R3.12)

- 71** Accessing study leave is problematic for doctors in training. Doctors in training stated that it is difficult to access study leave due to the demands of the rota. They commented that their leave is blocked by junior department administrators.
- 72** Doctors in training are told how to apply for study leave during induction. However, they did say the intrepid system which is used to book study leave is complicated and difficult to use. Doctors in training also told us that they feel there has been a rise in the amount of staff absences due to sickness at the trust. This in turn creates pressure on the rota and the need for additional locums which impacts on the doctor in training's ability to access the full opportunities in the trust.
- 73** The educational supervisors we spoke to felt that study leave is accessible for doctors in training and had not heard about the problems learners were having trying to book study leave.

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

- 74** Doctors in training told us that they do receive feedback from their supervisors on their progress and performance. However the quality and detail of this feedback does depend on the consultant who is giving it. Doctors in training felt feedback is not standardised although this has been raised with senior management and the consistency of feedback is improving.

Meeting the required learning outcomes (R3.15)

- 75** The trainers that we met during the visit stated that the major challenge preventing them from ensuring doctors in training meet their required learning outcomes is trying to remove the administration burden. They commented that there is a need to improve the availability of training for all including trust grade doctors and to keep the rotas safe. They noted that this may involve consultants acting down to ensure patient safety and a suitable balance between training and service on the wards.
- 76** We heard about a longstanding issue with core doctors in training not being satisfied with the training experience they were receiving. Core doctors in training were not able to attend clinics which made it difficult for them to achieve their learning outcomes, however the trust have worked to improve this. This includes the initiative of the clinical experience week where learners attend clinics all week. The clinic weeks have helped core doctors in training to access clinics. Furthermore, due to the work the trust has done, now core doctors training in anaesthetics said their level of training is good with a suitable balance between supervised and unsupervised work. They stated that they have access to a lot of teaching and support and they are able

to move around different subspecialties. Also, core doctors training in diabetes stated that they are actively encouraged to attend clinics; have two days specialist teaching and can now have bleep free periods where they can access various learning opportunities.

Career support and advice (R3.16)

- 77** Doctors in training state that they receive good career support and advice from their educational and clinical supervisors. Foundation doctors also told us that there is a careers day planned for them in the near future.

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)

- 78** At the beginning of the visit, senior managers told us about the investment they have made in their staff and their commitment to education. Staff at the trust have been given honorary titles from the University of Leicester which has been received enthusiastically. There was also a recent reception dinner for academic champions in the trust. They have appointed education leads at the trust who regularly meet to share good practice.
- 79** Educational supervisors we met told us that they enjoy their role although it is very busy. Prior to the visit, in the document submission the trust provided, it was evident that there was a lack of evidence for the dedicated and consistent application of teaching time in most job plans. The supervisors we met stated the trust have made efforts recently to ensure the consistent application of SPA time in their job plans. Overall, educators at the trust feel well supported and they appreciate the quality of training they access from HEE EM. Those who teach and supervise undergraduate students feel well supported by the medical school as well.
- 80** Both educational and clinical supervisors told us that there is a clear appraisal system at the trust. They commented that the education section of appraisal is not done electronically so can sometimes feel like a 'bolt on' however they appreciate the recognition of their education achievements and training needs. We heard that clinical supervisors have done some form of supervisory training. Also supervisors are supported to deliver teaching and receive examiner training.
- 81** Some supervisors commented that there is a tension between education, training and service delivery particularly in cardiology. This has led to supervisors occasionally delivering extra hours outside of the time identified for education in their job plans. Senior managers told us that they do find it difficult to recruit supervisors because of this however they do presentations at new consultant inductions to tell them about the benefits of being a supervisor.

Time in job plans (R4.2)

- 82** The trust has done a great deal to ensure the fair distribution of time in job plans. However they do realise that there is still some way to go to ensure that all clinical

and educational supervisors feel a sense of equity in what they have been allocated and what they are expected to achieve in this time. For postgraduate medical education, educators told us that there is more explicit guidance and support in regard to time in their job plans for education and training.

Educators' concerns or difficulties (R4.4)

- 83** Educators told us that in cardiology, they are still under a lot of pressure. They stated that all cardio-respiratory acute admissions are managed at the Glenfield site so there is an increase in the number of patients there. As a consequence, educators state that they need an increase in the number of consultants at Glenfield to manage the increasing number of admissions. The fact that resources are stretched is affecting the morale of educators in this department.

Working with other educators (R4.5)

- 84** Educators we met with told us that there is a strong academic and research stream at the trust. Educators state they are working together to ensure that there is adequate ward cover at a senior level to enable the training of doctors and procedural activity.

Theme 5: Developing and implementing curricula and assessments

Standard

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

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

Informing curricular development (R5.2)

- 85** Prior to the visit, we heard that Leicester Medical School had made changes to their curriculum. The educators we spoke to told us how they informed the curriculum changes at Leicester Medical School through attending regular meetings with colleagues at the school and exploring how they could best support the delivery of the curriculum.
- 86** Medical students told us that they have learnt about prescribing through their placements. They stated that this is slightly easier at Glenfield as there is the opportunity to see written prescriptions whereas at the other sites, it is mainly computer based and there are a small number of computers. Furthermore, medical students found that in various departments there are different prescribing practices and different drug charts which can be difficult to adjust to at first. In the clinical skills centre, medical students are encouraged to practice prescribing using different scenarios.

Undergraduate clinical placements (R5.4)

- 87** The undergraduate clinical placements give medical students sufficient practical experience to achieve the outcomes for graduates. Students we met told us that they enjoy learning about the treatment of an interesting, diverse patient population. Students say in the best clinical placements, the doctors enjoy teaching them and they learn a great deal from other professionals on the wards too.
- 88** However, the students we met did tell us that they find the delivery of the undergraduate curriculum can be incoherent in regard to its structure. Furthermore, the quality of their clinical placement is dependent on the department or site. We heard how students had been turned away in orthopaedics or had difficult experiences when working in general medicine. Students told us that their experiences varied according to the block they were in. They also commented that in some of the more poorly organised placements, bedside teaching is non-existent.

Recommendation 2: The trust should consider how they teach and deliver the undergraduate curriculum as currently their implementation lacks the coherence and structure it needs to ensure students value their learning experiences in the Leicester hospitals.

Examiners and assessors (R5.8)

89 During our visit, we heard that all examiners and assessors are trained appropriately for their role in the delivery of undergraduate medical education. Senior managers ensure that assessments are carried out by those that have the correct expertise in the area being assessed.

Training programme delivery (R5.9)

- 90** The quality of the training programme delivery is variable. Doctors in training we spoke to state that the quality of the programme delivery depends on who is managing it or the site in which they are doing this training. We heard from doctors in training at the Glenfield site that the quality of teaching here is excellent. They find the teaching very useful and enjoy the contributions from the whole team including the nurses which is essential for meeting their learning needs.
- 91** Doctors training in general internal medicine told us that, although they fulfil the requirements of the programme in general, a lot of training opportunities are lost. This is because at University Hospitals of Leicester NHS Trust, many of the general medicine departments are specialised and therefore there is little opportunity for cross over. Furthermore, they found that doctors in training were so busy that a lot of the work which relates to their training is unrecognised. Some doctors training in cardiology and gastroenterology felt their responsibility to provide cover to other departments was of little educational value and was affecting their access to necessary training opportunities.
- 92** The trainers we spoke to did report some issues with the training programme delivery at the trust. They stated that despite the trust having one of the largest intensive care units, there was an issue with the utilisation of this unit. They felt that the capacity of the intensive care unit was not taken into account when planning education and training opportunities. The trainers we met commented that core doctors in anaesthetic training, for example, were not exposed to enough out of hours work at the trust. Also as these core doctors were not working on call then they were not getting some key clinical experiences in their training. As a consequence, trainers did note that in their opinion, the level of core doctors in Leicester was quite novice in comparison to others in the country.
- 93** The core doctors in training we spoke to did feel that they were meeting all of their curriculum and assessment requirements and found the core medical training procedural skills day a helpful resource. Senior managers at the trust told us they are hoping to do another procedural skills day this year.

Requirement 5: The trust must ensure that all core doctors in training are given sufficient experience to achieve and maintain the clinical and medical competencies required by the curriculum.

- 94 Doctors in training also relayed their concerns about the impact of missing a teaching session. This concern was particularly prevalent amongst doctors in the second year of foundation training (F2) where each of their teaching sessions is organised over a whole day. They commented that they have to attend at least 70% of the teaching sessions organised for them. In F2, they have ten teaching sessions a year so if they miss three of these due to being on call or on leave/zero days at the time then this has an impact on their training. F2 doctors shared their fear of not meeting the 70% attendance threshold especially those working on busy medicine wards that could not always be released to attend teaching. Some F2 doctors felt missing teaching due to being on call made them exempt from the requirement as long as this was recorded ahead of their ARCP. F2 doctors state that they would like some clarification about the implication on their training if they cannot attend enough of the teaching sessions.

Requirement 6: The trust must ensure that all doctors in the second year of foundation training are able to fulfil the requirements of their curriculum and attend required teaching sessions.

Examiners and assessors (R5.11)

- 95 In the documentary evidence submitted prior to the visit and in meetings with educators at the trust, it is clear that assessments are carried out by those with expertise in the relevant areas. All educators undergo training to ensure that they are effective in assessing the performance of doctors in training.

Reasonable adjustments in the assessment and delivery of curricula (R5.12)

- 96 Doctors in training said that the trainers are accommodating and ensure that reasonable adjustments are made when needed to ensure the consistent assessment and delivery of the curriculum. They said the training programme directors are particularly helpful in this regard. The educational and clinical supervisors stated that they understood the importance of making reasonable adjustments where applicable.
- 97 However we did hear from medical students that sometimes they had formative exams designed by block leads where images of x-rays were displayed on powerpoint for them to interpret and in instances like these, reasonable adjustments were not always implemented. For example, students stated the powerpoint image was displayed in the same way, same size and for the same amount of time for all students even those with identified special needs. Therefore there was no reasonable adjustment made for those with dyslexia in the class. We spoke to the block leads and they stated that they just wanted to give the students an accurate impression of what the real summative exam would involve however this showed a

misunderstanding of reasonable adjustments. We got a sense from our discussions with the block leads that there was a poor understanding of the reasonable adjustments that need to be made for learners to ensure that they can meet the necessary standards of competence. This includes adjustment to assessments to accommodate specific disabilities.

Requirement 7: The trust must ensure that all staff understand the importance of making reasonable adjustments for medical students when needed and when to take appropriate action to accommodate adjustments to assessments.

Team leader	Professor Jacky Hayden
Visitors	Professor Anoop Chauhan Ms Katherine Marks Professor Paul O'Neill Dr Anna-Maria Rollin Dr Vivek Srivastava
GMC staff	Mr Kevin Connor Ms Abigail Nwaokolo

Professor Sue Carr
Director of Medical Education
Tel: 0116 258 6402
PA: Harjinder Badyal
Tel: 0116 258 6200

Dept of Clinical Education

Level 2 Jarvis Building
Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW

Our Ref: 887SC/HB

9th May 2017

Lucy Llewellyn, Education Quality Analyst
Visits and Monitoring Team
Education Quality
Education and Standards Directorate
General Medical Council
Regents Place, 350 Euston Road, London NW1 3JN

Dear Lucy,

GMC Visit to the University Hospitals of Leicester NHS Trust: Response from the Trust

Thank you for giving us the opportunity to respond to the GMC report following your visit on the 25th October 2016. We were very pleased that the report identified areas of good practice and numerous areas that are working well. We particularly appreciate the recognition of our internal education quality and governance processes, strong education team and the engagement of a lead Non-Executive Director and Patient Partner who represent education in UHL.

However, we are aware that there are still improvements to be made to ensure that we continue deliver high quality Undergraduate & Postgraduate training at the University Hospitals of Leicester.

In response to the GMC recommendations:

- 1. Improving work and social space to meet learner's needs:** In addition to the opening of the Odames Library, the Trust has recently developed a multi-professional education facilities strategy, which is being progressed as part of the Trust reconfiguration programme. This strategy will enhance the work space available for learners across the Trust.

In response to the GMC requirements:

2. The Trust should ensure they have appropriate systems in place to collect feedback from learners on undermining and harassment: The Trust take this issue extremely seriously and are committed to improving in this area. The Department of Clinical Education is working closely with Human Resources to improve systems and ensure learners feel supported and are more aware of mechanisms available to raise concerns.

3. Doctors in Training must not share their login details or leave computers logged on: We are proactively working with the Trust Information Technology Department to address this issue.

Kind regards.

Yours sincerely,



Professor Sue Carr
Director of Medical Education/Associate Medical Director

cc Andrew Furlong, Medical Director

