General
Medical
Council

Visit report on South Eastern Health & Social Care Trust

This visit is part of the 2017 Northern Ireland national 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	South Eastern Health & Social Care Trust
Sites visited	Ulster Hospital (UH)
Programmes	- Undergraduate - Foundation - Core medical training (CMT) - Core surgical training (CST) - General (internal) medicine (GIM) - General surgery - Obstetrics and gynaecology (O&G)
Date of visit	20 March 2017
Overview	The South Eastern Healthcare and Social Care Trust (hereafter referred to as the trust) is one of five trusts that provide health and social care in Northern Ireland. The trust manages five hospitals within the region – The Ulster Hospital which is the main acute hospital, two local hospitals Downe and Lagan Valley and two community hospitals Ards and Bangor. This report reflects the finding of our visit to Ulster Hospital. Although we only visited the one hospital site,

those we met spoke of their experience of medical education and training across all sites managed by the trust and this report reflects the comments we heard on the day. During the visit we met with the trust's education management team, medical students from Years 3, 4 and 5 of Queen's University Belfast School of Medicine, Dentistry & Biomedical Sciences (QUB), doctors in training, and clinical and educational supervisors.

In general, the medical students and doctors in training we met with spoke favourably of the medical education and training offered by the trust. Whilst we heard that the balance between workload and training appears to be good, service pressures do impact on the educational opportunities available and we heard of a number of initiatives being employed both at trust and departmental level to counteract this.

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 1: Learning environment and culture (R1.3)	Within surgery, we heard that morbidity and mortality meetings present a positive and supportive opportunity both for learning and providing feedback to doctors in training.
2	Theme 1: Learning environment and culture (R1.7; R1.8)	Doctors in training described good supervision, appropriate to their level of training.
3	Theme 1: Learning environment and culture (R1.12)	Where rota gaps exist, doctors in training are given the opportunity to undertake additional short shifts. This initiative, developed in conjunction with doctors in training, helps to alleviate service pressures.
4	Theme 1: Learning environment and culture (R1.15)	In surgery, the vertical team-based structure encourages a sense of belonging and supports a tailored educational experience for doctors in training.

5	Theme 1: Learning environment and culture (R1.22)	The Safety, Quality, Experience (SQE) programme encourages those employed within the trust to identify and develop initiatives that support patient safety and quality improvement. This philosophy appears to be embedded within the organisation.
6	Theme 2: Educational governance and leadership (R2.1)	We found an effective educational governance system operating at different levels within the trust and clear links to the trust board.
7	Theme 5: Developing and implementing curricula and assessments (R5.9)	The balance between workload and training appears to be good across a range of specialties.

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 1: Learning environment and culture (R1.11)	Doctors in training must only take consent for procedures appropriate for their level of competence and for which they understand the associated risks and alternative treatment options.
2	Theme 1: Learning environment and culture (R1.13)	Timetabling of induction should be reviewed and reconciled with the rota, where needed.
3	Theme 3: Supporting learners (R3.1)	Learning outcomes from equality and diversity training must be clearly understood and applied in practice, such that learners are able to demonstrate they meet the professional standards required of them. Equality and

		diversity training must be appropriately monitored, and learners and educators must be up-to-date with their training.

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 1: Learning environment and culture (R1.14)	Handover in all specialties should be organised and scheduled to maximise the learning opportunities for doctors in training in clinical practice.

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', eg 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 The importance of reporting patient safety concerns and the different methods by which to do so is outlined in a welcome letter sent by the Director of Medical Education to doctors in training beginning their placement at the trust and, is also discussed during induction.

2 During the visit, we heard from doctors in training that concerns are more often raised with individuals (for example, clinical or educational supervisors). Whilst there was an awareness of the online and paper based reporting systems in use within the trust, few appeared to have ever used them, preferring instead to report any concerns to a senior colleague.

3 We did not hear many examples of concerns being raised however those we met appeared comfortable in doing so should the need arise. Generally, we found the culture within the trust to be supportive, encouraging students and doctors in training to raise concerns without fear of adverse consequences.

Learning from mistakes (R1.3)

4 In order to encourage learning from mistakes and reflection, the trust emails learning summaries of patient safety concerns to relevant members of staff and we heard reference to this from those we met with.

5 We heard that in surgery, morbidity and mortality meetings provide an opportunity to both present and discuss cases in an open, supportive and blame free environment

and the foundation doctors and core doctors in training we met with particularly valued this.

Area working well 1: Within surgery, we heard that morbidity and mortality meetings present a positive and supportive opportunity both for learning and providing feedback to doctors in training.

Supporting duty of candour (R1.4)

6   Whilst there is no statutory duty of candour in Northern Ireland many, but not all, of the medical students and doctors in training we met with were familiar both with the term duty of candour and the core principles supporting it.

Seeking and responding to feedback (R1.5)

7   None of the doctors in training we met had received personal feedback to a patient safety concern. This was possibly due to the fact that the submission had been made by an intermediary such as an educational or clinical supervisor, or had been submitted anonymously. Those we spoke to were confident that the trust does investigate concerns raised and, where necessary, take action.

Educational and clinical governance (R1.6)

8   During the visit, we heard that the trust has developed an initiative to actively promote patient safety, quality improvement and patient experience (SQE). This initiative encourages the reporting of patient safety concerns by all staff. Doctors in training we met with were aware of this initiative and had been invited to contribute.

Appropriate capacity for clinical supervision (R1.7) & appropriate level of clinical supervision (R1.8)

9   All doctors in training with met with confirmed that clinical supervision is available and appropriate for their level of training.

Area working well 2: Doctors in training described good supervision, appropriate to their level of training.

Taking consent appropriately (R1.11)

10   We heard mixed experiences with regard to doctors in training taking consent. The majority of those we spoke to were unaware of any formal consent training offered by the trust and, there was little reference or understanding of trust policy, although there was some awareness of GMC guidance on the subject.

11   The majority of doctors in training we met were aware that consent should only be undertaken for procedures appropriate to their level of competence and we heard

that support or guidance would be sought from a more senior colleague when necessary.

12   The process for obtaining consent within O&G differs from other departments within the trust and this raised a concern that foundation doctors may be taking consent for procedures beyond their level of training. We heard that patients undergoing procedures are provided with information leaflets that explain the intervention and are also given further information with regard to the associated benefits, risks and possible complications. During pre-assessment, and having witnessed that the patient had been given this information, foundation doctors in training may then confirm patient consent. If, at this point, the foundation doctor in training is unable to answer any questions the patient may have, or the procedure is complex, the consultant or a more senior doctor in training is asked to obtain consent prior to the procedure being undertaken.

13   There was a concern that this process may result in doctors in training confirming consent for procedures beyond their level of competence. Furthermore, the process as described, does not allow patients the opportunity to discuss their treatment in a timely fashion, so that they are able to make an informed decision and confirm consent prior to the procedure being undertaken.

Requirement 1: Doctors in training must only take consent for procedures appropriate for their level of competence and for which they understand the associated risks and alternative treatment options.

Rota design (R1.12)

14   As in many trusts, workload pressures can mean that it is difficult to balance service requirements with educational and training opportunities and this was noticeable in discussions with those undertaking foundation training. This supports the results of the GMC national training survey which recorded a lower than average score for workload in foundation medicine years 1 and 2 and foundation surgery year 1 at the Ulster site. Workload pressures were not solely limited to foundation doctors however, core and higher doctors in training considered the balance between service and training to be good.

15   As would be expected, workload pressures are compounded by rota gaps and we heard that the trust attempts to address this with the use of locums and cross cover between some specialties.

16   In documentation submitted ahead of the visit, the trust advised that rotas are designed and regularly reviewed in order to maximise training opportunities. In general, those we met spoke favourably with regard to the time available for education and the support available to them.

17 We heard that in the past, when concerns had been raised with regard to out of hours workload, the trust met with rota co-ordinators and doctors in training to identify a solution. One idea, proposed by foundation doctors, was to offer the possibility of additional shorter shifts. This idea has proved popular with doctors in training who are more willing to commit to shorter hours.

Area working well 3: Where rota gaps exist, doctors in training are given the opportunity to undertake additional short shifts. This initiative, developed in conjunction with doctors in training, helps to alleviate service pressures.

Induction (R1.13)

18 We heard that, in advance of their start date, postgraduate doctors in training are sent information by the HR department. It includes, but is not limited to, trust and departmental contacts, instructions on how to access IT systems and details of online training modules to be undertaken prior to taking up post. This is then followed, on their first day in post, by a departmental induction which covers information specific to each placement and a tour of the hospital.

19 Foundation doctors in training receive a more detailed four day induction, arranged by the trust in conjunction with the Northern Ireland Medical and Dental Training Agency (NIMDTA). This includes a period of work shadowing, focused teaching on trust IT systems and information and guidance on trust policies and procedures.

20 On the whole, those we met spoke favourably of the induction process. We did note some variability with regard to the delivery of departmental inductions, with doctors in training favouring information being conveyed by a member of the department over a paper based approach.

21 For some, specifically foundation doctors starting placements at night, the timing of their induction appeared to be a concern. We heard that it was possible for doctors in training to start their first night shift having attended their induction that morning. Although not required to attend teaching later that day, it was felt that timetabling could be improved in order to reduce the risk of fatigue.

22 Furthermore, we heard that it was possible for a doctor in training to undertake their first night shift without having undergone an induction. We were advised that in such circumstances, induction would be conducted separately however it was unclear how this would be monitored and how such an individual would be identified.

Requirement 2: Timetabling of induction should be reviewed and reconciled with the rota, where needed.

Handover (R1.14)

23 Those we met confirmed that handover does take place, although the overall impression was that it was transactional with little mention made to the educational value of the process.

24 Some of those we met considered handover to be daunting. However others, whilst still acknowledging the challenges, made reference to the respect proffered by colleagues.

Recommendation 1: Handover in all specialties should be organised and scheduled to maximise the learning opportunities for doctors in training in clinical practice.

Educational value (R1.15)

25 The South Eastern Health & Social Care Trust manages five hospitals across the region, the Ulster site being the largest. Understandably, each site offers a different learning experience and we heard that doctors in training value the time spent at the each hospital for different reasons. Whilst the Ulster site offers a broad range of clinical experience, we heard that in the smaller hospitals doctors in training appreciate the opportunity to discuss cases in real time and are more likely to be able to attend teaching. We heard that in order to benefit from the training opportunities within the trust, doctors in training rotate between sites.

26 All those we met with agreed that clinical placements within the trust provided appropriate learning opportunities and a breadth of experience and that both clinical and educational supervision provides adequate feedback with regard to performance.

27 General surgery at the Ulster hospital operates a vertical team based structure and many of those we met felt that this optimised the learning and feedback opportunities available within the department. We heard that doctors in training are allocated to one of three teams, each of which includes four consultants. The benefits to this arrangement are many, but overwhelmingly we heard that doctors in training feel well supported by their colleagues and value the fact that consultants are visible within the department. Educational and clinical supervisors we met also valued the team structure stating that it allows them to understand the training needs of each doctor in training, provide supervision appropriate to the level of training and give tailored feedback.

Area working well 4: In surgery, the vertical team-based structure encourages a sense of belonging and supports a tailored educational experience for doctors in training.

Protected time for learning (R1.16)

28 Throughout the course of the visit, we heard details of the in-house training opportunities provided within the trust and these were valued by the doctors in training we met with.

29   Unfortunately, on occasion, the pressure of work prevents doctors in training from attending such training and we heard that this was more often a problem at the Ulster Hospital compared to other smaller hospitals managed by the trust.

30   We also heard that for some training time is not protected and, that whilst they are able to attend they do so whilst continuing to carry the on-call bleep.

Multiprofessional teamwork and learning (R1.17)

31   Prior to the visit, the trust had described how doctors in training are encouraged to work with other healthcare professionals.

32   We heard numerous examples throughout the day of both medical students and doctors in training working with, and learning from, other healthcare professionals such as advanced nurse practitioners and pharmacists. Whilst, on occasion, this appeared to coincide with formal teaching events, we also heard examples of informal on the job learning activities taking place. Doctors in training across all grades were able to cite examples of multiprofessional learning and it was apparent that this practice is both valued and appreciated.

33   Furthermore, we also heard examples of doctors in training conducting audits and contributing to quality improvement projects in collaboration with colleagues from other healthcare professions.

Adequate time and resources for assessment (R1.18)

34   Students, doctors in training and their educational and clinical supervisors confirmed that there is sufficient time available to complete assessments and that these are being undertaken in line with curriculum requirements.

Capacity, resources and facilities (R1.19)

35   From conversations held on the day of the visit, it was apparent that the learning experience differs across hospital sites managed by the trust. We heard examples of limited training opportunities available at sites outside of the main acute hospital site, however we also heard of actions taken to address such concerns. Whilst smaller hospitals provide less practical experience, doctors in training spoke favourably of the teaching available at these sites.

36   In 2014, the trust opened a Quality Improvement and Innovation Centre (QIIC). This facility is used for a multitude of purposes that support education and training, such as hosting the delivery of internal and external training courses. However, it wasn't clear from those we spoke to whether the centre provided a suitable environment for individual learning.

37 Both students and doctors in training we met with confirmed that internet access is available across the Ulster site.

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

38 Simulation facilities within the trust are located within the QIIC. At the time of the visit, the trust had recently appointed a simulation lead whose role, in the first instance, is to expand the simulation facilities available to medical students before addressing the wider needs of those in postgraduate medical training.

39 Medical students we met were aware of the simulation facilities available and how to access them.

40 Doctors in training were largely unaware of the facilities available within the simulation suite, instead making reference to acquiring skills directly within the clinical environment or via courses developed by external organisations but delivered locally, such as IMPACT (Ill Medical Patients' Acute Care & Treatment) or PROMPT (Practical Obstetric Multiprofessional Training).

Access to educational supervision (R1.21)

41 From foundation through to higher medical training, those doctors in training we met with confirmed that they meet with their educational supervisors regularly and no concerns were raised with respect to this requirement.

Supporting improvement (R1.22)

42 In 2011, the trust introduced the Safety, Quality and Excellence training programme. The purpose of the programme is to both encourage and support health and social care professionals wishing to engage in quality improvement projects that impact patient care and experience. Delivered over a period of nine months, participants are taught the skills required to successfully undertake a quality improvement project. Activities encourage collaboration with both immediate colleagues and across multidisciplinary teams. The QIIC, provides space to both accommodate and expand the existing programme.

43 Doctors in training we spoke to were aware of the SQE initiative and recognised the benefits such a programme could bring both to patient care and in the development of their own skills set. Ahead of the visit, the trust submitted a list of all projects completed by doctors in training between 2012-2016 demonstrating to the visit team the breadth of topics covered.

Area working well 5: The Safety, Quality, Experience (SQE) programme encourages those employed within the trust to identify and develop initiatives that support patient safety and quality improvement. This philosophy appears to be embedded within the organisation.

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)

44 The trust has a robust educational governance structure with clear links to the trust board.

45 We were told that the Director of Medical Education (DME) meets formally with the Medical Director three times a year and submits a report, detailing issues affecting medical education, to the trust board annually. We heard that the DME Chairs the Foundation Board and Medical Education Committees both of which are attended, alternately, by the Medical Director.

46 We also heard that the trust has good working relationships with both QUB and NIMDTA and heard detail of a number of joint appointments such as training programme director and head of school demonstrating cross organisational working.

Area working well 6: We found an effective educational governance system operating at different levels within the trust and clear links to the trust board.

Evaluating and reviewing curricula and assessment (R2.4)

47 The trust is visited once a year by QUB but in the interim, the QUB Sub-Deanery Committee meets four times a year to discuss issues affecting undergraduate medical education including curriculum reviews and reviews of student placement evaluations.

48 Medical students we met with confirmed that they submit an online feedback evaluation at the end of each placement. We heard that evaluations are collated by QUB and fed back to the undergraduate sub-dean to disseminate and action. The trust reports back to QUB twice a year on actions taken.

49 We heard from doctors in postgraduate training that evaluation of clinical placements occurs via the GMC National Training Survey (NTS). Both prior to and during the visit

the trust provided an example of how a concern that had been raised via the NTS was addressed in collaboration with doctors in training and NIMDTA.

50 We also heard of a number of informal methods by which feedback is both sought and acted upon. We heard mention of educational supervisors encouraging feedback and concerns and comments being directed to undergraduate administrative staff. Informal feedback is encouraged by the trust as it presents an opportunity to address the concern in a timely manner.

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

51 The trust confirmed that they do not collect equality and diversity data and are therefore are not in a position to evaluate information about learners' performance, progression and outcomes.

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

52 The trust confirmed that they have a learning development agreement with NIMDTA that is reviewed annually and a service level agreement with QUB. The service level agreement remains in place for a period of five years, the most recent version of which was submitted by the trust for review ahead of the visit.

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

53 The education management team confirmed that they are in regular contact both with QUB and NIMDTA to discuss issues relating to education and training and spoke favourably about the support offered by both organisations. This sentiment was echoed by educational and clinical supervisors who confirmed that a two way dialogue exists both in terms of monitoring the educational environment and taking action to address concerns and make improvements.

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

54 The trust confirmed that time is allocated in job plans for educational responsibilities. Please see R4.2

Educators for medical students (R2.13)

55 Undergraduate training within the trust is overseen by the undergraduate sub-dean. The undergraduate sub-deanery structure is such that representation is available at all hospital sites managed by the trust. The undergraduate sub-deanery meets quarterly to discuss issues relating to undergraduate medical education, review placement feedback and respond to QUB quality management visits.

Clinical supervisors for doctors in training (R2.14)

56 No concerns were raised with respect to this requirement. Doctors in training we met with confirmed that they do have a named clinical supervisor.

Educational supervisors for doctors in training (R2.15)

57 No concerns were raised with respect to this requirement. Doctors in training we met with confirmed that they do have a named educational supervisor.

Managing concerns about a learner (R2.16)

58 It is a NIMDTA requirement that educators attend a 'Supporting Trainees' course and educational and clinical supervisors we met confirmed this.

59 Whilst during the course of the visit we heard several examples of how doctors in difficulty had been supported by the trust, we did not see any evidence either ahead of the visit or on the day of a formal process detailing the support available or the process to be followed.

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)

60 Across the spectrum of training grades, we found there to be an awareness of the professional standards set out in good medical practice. We heard examples of some ethical dilemmas faced by doctors in training and, whilst we did not see evidence of a formal method by which to raise concerns, we did hear examples whereby informal support had been sought from senior colleagues.

61 Doctors in training were aware that iQuest, a modular professional skills framework programme developed by NIMDTA, includes a module that examines the key principles governing good medical practice.

62 Many of the doctors in training we met with confirmed that they had undertaken equality and diversity training via an online training module. For some, the module was considered to be overly long and difficult to relate to. Furthermore, few of those who had undergone the training could recall the content of the course in any detail or explain how the principles of equality and diversity are applied within the trust.

63 Equality and diversity training is a mandatory requirement for clinical and educational supervisors and those we met confirmed that this does occur.

Requirement 3: Learning outcomes from equality and diversity training must be clearly understood and applied in practice, such that learners are able to demonstrate they meet the professional standards required of them. Equality and diversity training must be appropriately monitored, and learners and educators must be up-to-date with their training.

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

64 Whilst some of the doctors in training we met did have knowledge of the confidential counselling and occupational health services available to them, for some there appeared to be a degree of uncertainty with regard to how such services could be accessed.

65 As with many of the issues we discussed during the course of the day, doctors in training said that if they required educational or pastoral support they would speak to their educational supervisor in the first instance. Again we heard several references to the supportive environment within the trust and a willingness amongst colleagues to help each other.

66 We did hear some examples in which formal tailored support had been provided to support learners' health and wellbeing and this appeared to work well.

67 We both heard and saw evidence of a careers seminar aimed at those in early training, however we saw no evidence of a formal careers advice and support service offered by the trust.

Undermining and bullying (R3.3)

68 Ahead of the visit the trust supplied a copy of their 'Working Well Together Policy'. This document provides information and guidance on how to manage conflicts both informally and formally.

69 Throughout the day many of those we spoke to made reference to a very helpful and supportive environment within the trust in which bullying and undermining would not be tolerated. Whilst we did hear some isolated examples of perceived bullying and undermining, where cases had been reported, they appeared to be being investigated and managed appropriately by the trust.

Information on reasonable adjustments (R3.4)[*]

70 Those we met appeared confident that should a reasonable adjustment be required, the trust would assist and accommodate this where possible. During the visit we heard several examples of the trust working closely with learners to both provide information and make adjustments where necessary.

Student assistantships and shadowing (R3.6)

71 The medical students we met were aware of the student assistantship programme (previously known as F0) and, in general, it was viewed positively providing an opportunity to become familiar with the working environment within the trust.

72 We heard that a period of work shadowing, when learners progress from medical school to foundation training, takes place over a period of two and a half days and again this was viewed favourably. Not all doctors in training had undertaken their undergraduate training in Northern Ireland and whilst we did not identify any specific training requirements required of this cohort, equally we did not hear of any bespoke training being offered by the trust as an introduction to the Northern Ireland healthcare system.

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[*] The Equality Act 2010 does not apply to Northern Ireland. The Equality Act 2010 is in force in the rest of the UK, but the Disability Discrimination Act 1995 and the Special Educational Needs and Disability (NI) Order 2005 remain in force in Northern Ireland.

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

73 We were advised by the trust that applications for less than full time training are submitted to NIMDTA in the first instance. Once approved, the trust works with learners to facilitate this and we heard several examples of this working in practice.

Study leave (R3.12)

74 Doctors in core and higher surgery and higher medicine confirmed that they are able to take study leave. Educational supervisors confirmed that study leave is accommodated as far as possible.

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

75 Medical students and doctors in training confirmed that consultant colleagues willingly participate in the assessment process. We heard that constructive feedback is delivered both informally throughout the course of the day and formally via work place based assessments in line with curriculum requirements.

Support for learners in difficulties (R3.14)

76 Prior to the visit the trust described the support available to doctors in difficulty both on a day to day basis via clinical and educational supervisors and via professional healthcare services. Doctors in training advised us that they would approach their educational supervisor if they were experiencing difficulties and, whilst there was occasional reference to support services the route to access this support did not always appear clear to those we spoke to.

77 We did hear some examples of the trust working with NIMDTA to support those whose progress had given rise to concerns. However, doctors in training would benefit from clearer guidance on the support available to them and the routes by which they can access it.

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 The educational and clinical supervisors we met with confirmed that they had applied to and been formally appointed to their role.

79 Educational and clinical supervisors appear to be well supported in their professional development. This includes training provided in-house, regionally via QUB and NIMDTA or offered by the relevant college. The educators we met confirmed that they are supported to attend internal and external training courses appropriate to their role.

80 We heard that there is no separate appraisal against educational responsibilities for educational and clinical supervisors. Instead, the supervisory role is discussed as part of the routine annual appraisal process.

Time in job plans (R4.2)

81 The trust confirmed that time for teaching is recognised in job plans and is included in the 1.5 SPA (supporting professional activities) allowance. A further 0.5 SPA is available to those with specific educational responsibilities however, this doesn't appear to be applied universally across all specialties.

82 The educational and clinical supervisors we met during the visit confirmed that time for their educational responsibilities is included in job plans.

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

83 Educational and clinical supervisors in obstetrics and gynaecology, medicine and surgery without exception all spoke highly of the support they receive from their immediate colleagues, colleagues from other specialties and the education management team. It was apparent from the discussions that took place that the supportive environment experienced by doctors in training is equally valued by their senior colleagues.

84 We heard examples of educators meeting routinely to discuss issues that arise within the department and working together to identify possible solutions. Where those issues involve concerns with regard to the progress of doctors in training, these

meetings provide an opportunity to share experiences and, where appropriate, target support.

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 clinical placements (R5.4)

85 Undergraduate medical training within the trust is the responsibility of the undergraduate sub-dean and overseen by the undergraduate sub-deanery committee.

86 Medical students we met spoke favourably of their time at the trust describing a friendly and supportive environment in which colleagues were eager to help each other. Students were aware of whom to approach should they have any routine questions and that concerns should be raised with the undergraduate sub-dean.

87 No concerns were raised with regard to the learning resources available on site and medical students appeared knowledgeable of the simulation training facilities available.

88 We heard good examples of medical students learning alongside students from other healthcare disciplines and also learning from associated healthcare professionals such as speech and language therapists and social workers.

Training programme delivery (R5.9)

89 Medical students and doctors in training spoke favourably of clinical placements undertaken within the trust, confirming that training posts provide sufficient practical experience to meet the curriculum and assessment requirements.

90 All doctors in training we met with had a named educational and clinical supervisor with whom they meet on a regular basis.

91 As mentioned earlier in the report, concerns were expressed with regard to workload faced by foundation doctors specifically at the Ulster site. However, in the main, core and higher doctors in training considered the balance between workload and training to be reasonable and this appeared to be true across all sites including Ulster.

92 The majority of those we met confirmed that doctors in training are able to attend clinics however this was not universal across the board. Furthermore, we heard that for some, time spent in clinics was a planned activity whilst for others it appeared to

be a more fluid arrangement with access to clinics encouraged as and when workload permitted.

93 A number of years ago, and in order to minimise the time doctors in training spend undertaking tasks of little educational value, the trust introduced a phlebotomy service. A report submitted by the trust ahead of the visit outlined the background to this decision and the subsequent monitoring that had been undertaken to determine the impact on medical education and service delivery.

Area working well 7: The balance between workload and training appears to be good across a range of specialties.

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

94 The trust confirmed that the transfer of information process works well and that they receive information relating to learners requiring reasonable adjustments in a timely fashion, both from QUB and NIMDTA.

95 We heard that, where possible, the trust works closely with learners and educators to accommodate specific needs and we heard examples throughout the day of how this had worked in practice. Importantly, we also heard from several sources that requests for reasonable adjustments are managed within the trust both efficiently and with compassion.

Team leader	Steve Ball
Visitors	Simon Carley Tom Foley Rhona Hughes Rakesh Patel
GMC staff	Kimberley Archer (Education Quality Analyst) Kate Bowden (Education Quality Analyst) Samara Morgan (Education Quality Assurance Programme Manager) Martin Hart - (Observer) Paul Knight - (Observer)