

## Visit Report on Gloucestershire Hospitals NHS Foundation Trust

This visit is part of the 2016 South West regional review to ensure organisations are complying with the standards and requirements as set out in [Promoting Excellence: Standards for medical education and training](#).

### Summary

<b>Education provider</b>	Gloucestershire Hospitals NHS Foundation Trust
<b>Sites visited</b>	Cheltenham General Hospital and Gloucestershire Royal Hospital
<b>Programmes</b>	Undergraduate: University of Bristol Medical School  Postgraduate: foundation, core medical training, acute internal medicine, cardiology, emergency medicine, gastroenterology, respiratory medicine
<b>Date of visit</b>	13-14 April 2016

### Areas working well

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

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

		<p>paragraphs.</p> <p>(<a href="#">See paragraphs 1-2</a>)</p>
2	Theme 3: Supporting learners (R3.2, R3.10 and R3.12)	<p>The Trust provides a supportive environment for doctors in training. We heard of robust structures in place for those with pastoral issues, that less than full time (LTFT) doctors in training are fully supported and that study leave is accessible and welcomed.</p> <p>(<a href="#">See paragraphs 67-69, 77 and 78</a>)</p>
3	Theme 4: Supporting educators (R4.1)	<p>Clinical and educational supervisors are well supported in their educational roles by the Trust. They are provided with adequate facilities, selected and trained appropriately and are encouraged to continue their professional development.</p> <p>(<a href="#">See paragraphs 86-88</a>)</p>

## Requirements

When the requirements that sit beneath each of our standards are not being met, we outline where targeted action is needed and map to evidence we gathered during the course of the visit. We will monitor each organisation's response to these requirements and will expect evidence that progress is being made.

Number	Theme	Requirements
1	Theme 1: Learning environment and culture (R1.11)	<p>The Trust must not allow foundation doctors to take consent for procedures that are not appropriate for their level of competence.</p> <p>(<a href="#">See paragraph 19</a>)</p>
2	Theme 1: Learning environment and culture (R1.14)	<p>The current system of handover between the emergency department and the rest of the hospital poses a clear risk to patient safety. The Trust must ensure a robust handover system between the emergency departments and the medicine departments in both hospitals to avoid any impact on patient care.</p> <p>(<a href="#">See paragraphs 33-36</a>)</p>

3	Theme one: Learning environment and culture (R1.7)	The Trust must ensure that workload does not affect the time for educational activities and supervision of doctors in training. ( <a href="#">See paragraphs 11</a> and <a href="#">63</a> )
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## 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
<p><b>S1.1</b> <i>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.</i></p> <p><b>S1.2</b> <i>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.</i></p>

#### *Raising concerns (R1.1)*

- 1 The doctors in training we met at both Cheltenham General and Gloucestershire Royal Hospitals told us that there is an open culture with regards to raising patient safety concerns in the Trust. They also reported that they are aware of and confident in following the Trust's processes for reporting concerns. The doctors in training highlighted that consultants are available when the junior doctors need support.
- 2 We met with year 3 and year 4 medical students from Bristol Medical School at both sites who told us that they have not been in a situation which required them to raise a concern. However they commented that they are encouraged to speak up if they identify a patient safety concern. If they had a patient safety concern, students told us that they would initially raise it with their educational supervisor or another doctor on the ward. Students informed us that they are not aware of any formal route or pathway for raising concerns.

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

#### *Dealing with concerns (R1.2)*

- 3 Doctors in core medical training at Cheltenham General Hospital commented that they receive feedback regarding incidents they report or concerns they raise. They also told us that they have seen the Trust take actions based on the concerns and

suggestions they had raised. Doctors in training in emergency medicine mentioned that in their department there is an effective procedure for raising concerns during the night.

- 4** Doctors in higher specialty training, however, said that they do not receive adequate feedback on the incidents they report on Datix (the patient safety and risk management system used by the Trust). The trainers we met at Gloucester Royal Hospital told us that the lack of feedback is generally due to the fact that doctors in training often do not provide an email address when they report an incident and it is difficult to identify the individual who raised the concern. However, doctors in higher specialty training reported that they do not receive much feedback regardless of whether they add an email address or not and it usually requires active chasing on their part to get feedback on an incident.
- 5** Nevertheless, doctors in higher specialty training also reported that the Trust acts on their concerns and provided us with an example when they had raised concerns about a locum consultant. As several doctors in training had voiced their concerns the locum consultant was not invited to work again at the hospital.

#### *Learning from mistakes (R1.3)*

- 6** The trainers in emergency and respiratory medicine we met at Gloucester Royal Hospital mentioned that the lunchtime handover sessions are often used as a forum to provide feedback on the incidents reported on Datix. Furthermore the Trust organises mortality and morbidity sessions where they invite consultants that have been involved in the reporting of incidents to present various cases. The trainers also told us about a newsletter which is published weekly by one of the other departments that presents cases of incidents raised and acts as a mechanism for providing feedback on concerns. The doctors in core medical training at Cheltenham General Hospital commented on the quality of the safeguarding team for Accident and Emergency. They told us that there is a dedicated section of the website where they would find useful guidance about dealing with different categories of patients.

#### *Supporting duty of candour (R1.4)*

- 7** All doctors in training we met told us that the learning environment supports an open culture and that they are aware of duty of candour. The trainers and supervisors in emergency and respiratory medicine met at Gloucester Royal Hospital informed us that aspects of duty of candour are taught in the mortality and morbidity teaching sessions. Duty of candour aspects are also covered in the lunchtime handover sessions and doctors in training receive formal training on duty of candour.
- 8** The trainers we met told us that medical students also get sessions on duty of candour during their final year at university. The students we met were unfamiliar with the term duty of candour. However, this might have been a matter of terminology because when asked about the learning environment and culture

students reported that they are encouraged to be open and honest with patients and colleagues about things that might have gone wrong.

#### *Educational and clinical governance (R1.6)*

- 9** All the doctors in training we met at both hospitals told us that they are aware of the Trust processes for raising concerns about patients or their training. They also said that they feel comfortable engaging with these processes. We heard of various cases when doctors in training had raised concerns which demonstrated a good level of confidence on their part and that they are engaged with local protocols.
- 10** As also mentioned above, medical students are not aware of specific procedures to follow if they have a concern, however, they also said that they are encouraged to voice their concerns and have done so with other doctors or their educational supervisor.

#### *Appropriate capacity for clinical supervision (R1.7)*

- 11** All doctors in training we met reported good access to clinical supervision within their department. All doctors in training praised the commitment and willingness of the consultants to support them. Doctors in training particularly commented on the availability of consultants out of hours. They told us of instances when they had phoned consultants during the night and they had come in to the hospital to help. Comparing between different departments, foundation doctors said that clinical supervision is better in medicine than in other specialties. However, all doctors in training we met said that the reason they receive good clinical supervision is due to the commitment of consultant to education. The majority of doctors in training told us that the levels of workload are heavy for them and consultants and this makes it difficult for consultant to provide the required level of support.

#### **Requirement 3: The Trust must ensure that workload does not affect the time for educational activities and supervision of doctors in training.**

- 12** The medical students we met at both sites told us that during their induction they are assigned a unit lead per group. They said that they meet regularly with the assigned doctor as a group or in one-to-one meetings.

#### *Appropriate level of clinical supervision (R1.8)*

- 13** The medical students we met told us that they are linked to a doctor on the wards so they are never unsupervised. They also commented on the willingness of other doctors to assist and guide them.
- 14** The doctors in training we met reported a good level of clinical supervision. They commented that this is mostly due to the commitment of the consultants who make real efforts to support them despite the high level of workload. In our meetings with

trainers at both hospitals, they acknowledged that the workload presents a real challenge, but they are dedicated to going beyond their standard duties to provide adequate clinical supervision to doctors in training.

#### *Appropriate responsibilities for patient care (R1.9)*

**15** All the doctors in training and medical students informed us that they are not asked to undertake tasks outside of their competence. The trainers told us that they work closely with doctors in training on wards and this enables them to determine the doctor's level of competence and confidence. This was supported by the doctors training at Cheltenham General hospital who commented that due to working closely as a team, registrars and consultants are able to quickly identify situations when doctors in training need support.

#### *Identifying learners at different stages (R1.10)*

**16** The medical students we met at Cheltenham told us that they feel people know what to expect of them. They introduce themselves as medical students and have been given red lanyards to wear, which separates them from doctors in training.

**17** We heard the term 'senior house officer' (SHO) quite often throughout the different meetings at both hospitals. The term is used to describe anyone above a foundation year 1 doctor (F1) and below a registrar. Therefore the use of this term makes it difficult for consultants, members of the multidisciplinary team and patients to differentiate between different levels of doctors in training and their levels of competence. This could potentially lead to doctors in training working beyond their competence or without adequate supervision.

**18** During our visit we heard of some good initiatives in identifying the level of doctors in training. At Cheltenham General Hospital we heard that in medicine the doctors in core medical training have a separate rota from the foundation doctors. They said this is very helpful because it differentiates between the levels of doctors in training at a glance. In the emergency department the names of the doctors in training are put on the wall and their level is specified next to their name. This is also a positive effort in identifying the different levels of doctors in training.

#### *Taking consent appropriately (R1.11)*

**19** We heard during our visit that foundation doctors routinely take consent for procedures outside their competence such as endoscopy in gastroenterology. Some of the trainers we met are of the opinion that there is extensive guidance available on how to take consent and doctors in training do not necessarily need to be competent on the procedure they are taking consent on. The GMC visiting team are concerned this may expose the foundation doctors as they might lack experience and may not fully understand all the risks involved in the procedure they are taking consent for. Requirement 1.11 of *Promoting Excellence* states that 'doctors in training must take

consent only for procedures appropriate for their level of competence' and that learners should follow the GMC guidance on taking consent. Paragraph 26 of the GMC guidance on consent (*Consent: patients and doctors deciding together, 2008*) states that if the responsibility for consent is delegated, doctors should ensure that the person they are delegating to is suitably trained and has sufficient knowledge of the proposed investigation or treatment.

**Requirement 1: The Trust must not allow foundation doctors to take consent for procedures that are not appropriate for their level of competence.**

- 20** Supervisors in cardiology told us that doctors in training in cardiology posts are not allowed to take consent for interventions outside their competence. The higher doctors and those in core medical training did not raise any issues with taking consent.

*Rota design (R1.12)*

- 21** Almost all doctors in training we met and their trainers highlighted the heavy workload issue at both hospitals across all departments and specialties. Doctors in training informed us that one of the main problems for the Trust is rota gaps which exacerbate workload issues and directly affect the balance between service provision and training. Doctors in training are not always placed on a rota based on their training needs, but mostly to provide the service. In medicine, doctors in training told us, rota gaps are sometimes identified two to three weeks in advance, but gaps are not always filled on time.
- 22** The foundation doctors we met at Gloucester Royal Hospital were particularly concerned about their rotas and workload. Apart from those in general practice and obstetrics and gynaecology posts, all other foundation doctors identified several issues with their rota design. In gastroenterology, foundation doctors are on the rota for 12 days in a row and they usually work longer than their contracted hours. We heard that at times there is one foundation year 2 (F2) doctor to manage about 60 patients on a ward, which could pose challenges to workload and providing the right care for all patients.
- 23** We did not hear examples where workload and rota gaps had affected patient safety. Doctors in training and their trainers told us that doctors in training work beyond their shifts and consultants act down to help with the workload. Doctors in training commented that significant aspects of their training needs are disregarded when designing rotas. For example, the way rotas are structured mean that doctors in training leave before the consultants and they rarely have the chance to observe the post take of their patients, therefore missing out on important learning opportunities.
- 24** When we met with the Trust's senior management team, they informed us that recruitment is a key objective for them. They acknowledged that the insufficient

number of doctors and workload is a major issue for the Trust. The senior management team told us their Trust has the lowest consultant per patient ratio in the South West. The Trust have recently recruited two new consultants in cardiology, two in respiratory medicine and one in emergency medicine and have agreed funding for five more consultants to be recruited.

- 25** In the meeting with the senior managers we heard that the Trust has also recruited three medical fellows and has received approved funding to recruit 15 more. The Director of Medical Education (DME) told us that medical fellows are usually individuals who have completed their core medical training and passed the membership examinations, but have not decided on the career pathway they want to follow. Their role in the Trust is solely for education purposes and they support doctors in training by teaching certain procedures.

### *Induction (R1.13)*

- 26** The medical students we met told us that they have a good induction at the start of their placement. This includes a tour of the hospital and information about what is expected of them. Students said they feel confident that they know all they need about their placement.
- 27** Foundation doctors receive a Trust induction at the start of the year. This is followed by a departmental induction, which we heard varies in quality and detail across departments. Generally, foundation doctors were content with the induction they had received. In respiratory medicine and gastroenterology there is a booklet available for induction and in these departments doctors in training also have a multiprofessional induction.
- 28** Doctors in core medical training at Cheltenham General Hospital said that there is a HEE SW induction when they start in the South West region and they have regional induction days which they attend. Doctors training in the emergency department received a very thorough induction. The emergency department at Cheltenham General Hospital also has an online induction containing several modules to work through on a dedicated section of the website. Doctors training in acute internal medicine and gastroenterology also praised the induction in their departments. In acute medicine the induction is completed before the doctors in training start their posts. Doctors in core medical training suggested that it would benefit them if the induction also included a briefing about rotas.
- 29** Doctors in higher specialty training also reported that they go through a computerised Trust induction when they start. This is followed by e-induction sessions on internet. Doctors in training also receive departmental induction and said that the induction in acute internal medicine and respiratory is thorough, however there is no departmental induction for general internal medicine. All doctors in training who had started in August had gone through the above induction process, but we heard of instances when doctors in training had started in November and had not received

their induction until four months later. The groups we spoke to were not aware of a HEE SW induction for doctors in higher specialty training.

#### *Handover (R1.14)*

- 30** Doctors in core medical training at Cheltenham General Hospital said that the emergency department has a very good handover system between teams within the department. Handover takes place three times a day. The evening handover includes a good ward round. Doctors in training in acute internal medicine also informed us of a three times a day format in their department. They also praised the use of handover sessions for education purposes.
- 31** Doctors in core medical training in other departments/ specialties said that handover sessions are variable. Usually handover is done on paper and sometimes it is difficult to trace patients' treatment history. The foundation doctors also reported some issues with the handover system in different departments. The trainers we met told us that the morning and evening handovers are multidisciplinary and have more of a focus on patients, whereas the lunchtime handover sessions have more time for education.
- 32** Doctors in higher specialty training said that the way the rota is designed poses a challenge to handover between teams in respiratory medicine. This group of doctors in training also mentioned that although handover sessions take place three times a day, they are not very effective and often lack educational value.
- 33** During our visit we were told about an issue with the interface between emergency medicine and other medicine departments. The emergency department at Cheltenham General Hospital closes at 10pm and patients are moved to other medicine departments or referred to the emergency department at Gloucester Royal Hospital. This closure at Cheltenham General Hospital impacts on the workload in the emergency department at Gloucester Royal Hospital where patients are moved to other medicine departments due to shortage of beds.
- 34** In the meeting with the Trust senior management team we heard that there are various safety measures linked to the handover of patients from the emergency department to the medicine department. The senior management team told us the patients who are transferred are logged into the Trust's electronic system. At Cheltenham General Hospital the ambulance services stop bringing in patients at 8pm, however the emergency department consultants work until 10pm and have a detailed handover with the medical registrar. This handover involves a plan of treatment for all patients that are being transferred from the emergency department. Senior managers said that the above handover procedure for transfers of patients between departments is also followed at Gloucestershire Royal Hospital.
- 35** However, doctors in training said that the handover between the late shift consultant in emergency department and the medical registrar does not always take place.

Sometimes a bed request is put on the system without a detailed reason for referral. Doctors in training reported issues with the electronic system (Patients First) which has caused issues with tracing patients as well as patient care.

- 36** We asked doctors in training if they had any examples of occasions when patient safety had been compromised, but were told that although there had been no such cases, there had been instances of near misses. Sometimes patients have been transferred to medicine wards with the wrong diagnosis and this delayed treatment. The doctors in training have raised this issue with their supervisors and Trust management. The trainers we met also acknowledged the issue with the transfer of patients between emergency departments to medicine wards. Doctors in training emphasised the need for medical gatekeeping and improving the communications between departments on interdepartmental transfers of patients.

**Requirement 2: The interface between the emergency department and the rest of the hospital poses a risk to patient safety. The Trust must ensure that the issue of handover between the emergency departments and the medicine departments in both hospitals is addressed to avoid any impact on patient care.**

*Educational value (R1.15)*

- 37** The majority of doctors in training we met reported that workload affects their training and teaching experience at both sites. Doctors in training told us that most of the time it feels like their posts are more focused on service provision rather than training. However, doctors in training also stressed that consultants and supervisors are very committed to training. In the emergency department there are a few consultants on the floor and doctors in training said that they are very keen to teach. The same was reported for acute internal medicine. Doctors in training in respiratory medicine said that workload makes it difficult for them to get teaching and they usually have to stay after their shifts.
- 38** The medical students we met at both sites reported good learning opportunities, through tutorials, ward based teaching and individual teaching with doctors. Medical students are invited and allocated a space in morning ward rounds. Students commented that doctors in training and consultants are keen to teach them. They have had the opportunity to take histories or examine patients under the consultants' supervision.

*Protected time for learning (R1.16)*

- 39** Although the foundation doctors we met reported a very busy environment at both sites, they said that generally they are able to attend their teaching sessions. Overall the doctors in training we met praised the quality and opportunities for learning in both hospitals. Doctors in higher specialty training said that they get a clinics list per

month, although sometimes they are unable to attend them due to service pressures. Some clinics also get cancelled due to workload.

- 40** The majority of doctors in training told us that generally when they give enough notice, rotas allow for them to attend teaching, courses or examinations. Consultants and their clinical supervisors sometimes act down to help with workload which allows doctors in training to attend their teaching events. Doctors in training spoke highly of the quality of clinics and teaching in gastroenterology, but they said there are only a limited number of clinics for them to attend. The doctors training in cardiology and the emergency department were content with the teaching they are getting in their departments. They said there are ample opportunities to learn and they get protected time for teaching as well as one-to-ones with consultants. In acute internal medicine doctors are also happy with the teaching they are receiving.
- 41** Doctors in higher specialty training said they receive good regional teaching for their specialties. Those in respiratory medicine posts attend two or three training days per year. Doctors in training also told us that specialty teaching in gastroenterology that is organised by HEE SW is very good. However, doctors in training in general internal medicine feel that they do not get enough regional training days. Doctors in training told us there has been only one training day in two years for general internal medicine.

#### *Multiprofessional teamwork and learning (R1.17)*

- 42** Medical students told us that they get the chance to work as part of a multiprofessional team and they are made to feel welcome. Students identified prescribing as a weak point and said they would appreciate more face-to-face teaching and training in this area. Some students have had teaching sessions with the pharmacy students, which they praised and said they would like more of.
- 43** Doctors in training spoke in positive terms of their relationship with nurses and other members of multiprofessional team. They specifically praised the hard work of ANPs and the support they are receiving from Physicians Associates (PAs).
- 44** Doctors in core medical training said that receive good multiprofessional teaching. In the emergency department doctors have teaching sessions with mental health professionals and physiotherapists. In respiratory medicine doctors in training attend sessions with physiotherapists and nurses. Doctors in training in gastroenterology told us that they have regular teaching sessions with dieticians and nutritionists.

#### *Capacity, resources and facilities (R1.19)*

- 45** The medical students we met praised the accommodation and living arrangements at both Cheltenham and Gloucester. Students also said that they have good IT facilities and internet connection. Doctors in higher specialty training also spoke positively of accommodation and facilities at both sites.

- 46** The foundation doctors we met at Cheltenham General Hospital said that the system for discharging patients needs to be upgraded. Recently, there has been an episode when the discharge summary system did not function for days and created a backlog of discharge summaries to be updated.
- 47** Non-training grade doctors (for example in clinical fellow posts) and other healthcare professionals are making up a significant part of the workforce. Whilst we heard that their presence was beneficial in addressing workload issues and rota gaps, it is important to recognise that where non-training grades are potentially competing for training opportunities with trainees in approved posts there is a risk of adversely affecting the education and training of regulated groups. We would expect the LEPs to monitor their educational capacity and manage any adverse educational impact that non-training grades and other healthcare professionals may have on doctors in training posts and medical students.

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

- 48** The medical students we met told us that they have access to good simulation-based learning both at the university and during their placements. The doctors in higher specialty training told us that the simulation-based training varies between different departments. Doctors in training in emergency medicine receive extensive simulation-based training, both at the Trust and regionally. F1 doctors also get one session of simulation-based training.

## 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)*

- 49** The senior management team told us that the Trust has a clear structure for the quality management of medical education. The Trust has established quality panels as a forum where doctors in training are represented and have the opportunity to discuss any issues with the training programme directors (TPDs). The senior managers said that they have pioneered the quality panels initiative in the South West region.
- 50** The senior management team informed us that the quality panels review the GMC national trainee survey and drive improvement; they keep a quality register and prepare a report that goes to the Medical Education Board. The Medical Education Board is accountable to the Education, Learning and Development Committee which is chaired by the Trust's chief executive (CEO). A member of the executive team is usually invited to attend the Medical Education Board meetings. The Medical Education Board members include nominated doctors in training, Trust tutors, the foundation programme directors, the academy dean for medical undergraduates, and the DME.
- 51** The supervisors we met said that the Trust takes education seriously. They said the Trust structure for quality managing education is open and transparent.

### *Accountability for quality (R2.2)*

- 52** The education management team told us that the main forum for discussing education at the Trust is the Education, Learning and Development (ELD) Committee which meets quarterly. The DME presents a report on education to the committee every six months. If an issue regarding education needs escalation it is taken to the Trust Board by the CEO. The education management team told us that education is presented to the Trust Board as part of a broader risk therefore we could not determine clearly the Board's direct accountability for medical education matters.

- 53** We heard from the doctors in training, the trainers and other education managers we met that the DME is very dedicated to education and is a champion for moving the education agenda forward in the Trust. The current CEO has demitted from office and the Trust has very recently appointed a new CEO who had not started at the time of the visit.
- 54** We heard from the education management team that they are changing the way education matters are dealt with in the Trust. They are establishing processes and systems to ensure a robust way of reporting education matters to the Board that avoids relying on individuals. Some of these changes involve the establishment of a workforce governance route and including the ELD minutes on the Trust Board agenda.
- 55** Some members of the education management team think that the reason that many issues are not raised at Trust Board level is because those issues are solved at the ELD board level. We also heard that the current issues requiring operational solutions are discussed in the directors meeting, whilst governance and broader issues are taken to the Trust Board. However, some members of the education management team told us that they think education is not represented in a helpful way at board level.

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

- 56** The doctors in training told us that they would feel comfortable to speak up about the quality of their training. Doctors in training would report any concerns to their supervisors in the first instance. The supervisors we met reported that they feel they have a voice and are heard when they raise concerns about medical education and training.
- 57** The senior managers and the education management team told us that they take into account learners views through the quality panel meetings for each specialty. The GMC NTS results and end of year placements survey results are discussed at these meetings and are used as a driver for improvement in the quality processes in medical education at the Trust.

*Evaluating and reviewing curricula and assessment (R2.4)*

- 58** Bristol Medical School is currently redesigning the undergraduate curriculum. We heard in the meeting with senior managers that all undergraduate deans and staff in the Trust have been invited to the curricula change meetings at the university. Representatives of the Trust also sit on the different specialty panels for updating the curricula.

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

- 59** The Trust senior management team told us that each undergraduate academy in the region has a strong identity and are independent from each other. They acknowledge that this is one of reasons why students perceive that they are getting different experiences between the placements across the academies. However, the senior managers told us that the disparity across Bristol Medical School's academy system is a positive aspect because it enables students to adapt to diverse working environments.
- 60** The educational supervisors informed us that the medical school visits the Trust regularly throughout the year. The medical school can provide any training that educational supervisors may require. The medical school also runs an appraisal process for the undergraduate supervisors.

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

- 61** The Trust senior management team told us that Bristol medical school collects students' feedback on placements centrally. This enables the medical school to compare and benchmark amongst the seven undergraduate academies that they work with in the region. The deans of the undergraduate academies meet regularly and share information with the undergraduate unit leads in each Trust.
- 62** The DME produces a report each August for Health Education England working across South West (HEE SW). HEE SW responds formally to the report each December. In addition, the DME attends the HEE SW meetings three or four times a year as well as other regular DME meetings in the region, which enable sharing of information and good practice as well as discussing common issues and problems. The programme directors for each specialty also have regular meetings with HEE SW and with each other.
- 63** The senior management team told us about an example where HEE SW had identified an issue with the organisation of teaching in cardiology in the Trust. The HEE SW visit was useful and the Trust was supported to increase the number of cardiologists and redesign the way teaching was organised.

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

- 64** The Trust senior managers informed us that they allocate supporting professional activities (SPA) time in job plans for all educational and clinical supervisors. Each specialty director is aware of the SPA time each trainer within their specialty needs. The senior management team told us that the SPA time allocation is transparent, however they recognised that there is a widespread issue with trainers not being able to use their SPA time due to service challenges. This was also supported by the supervisors who confirmed that they do get time for education in their job plans, but they struggle to use the time allocated because of service pressures.

*Educators for medical students (R2.13)*

- 65** The medical students we met at both hospitals told us that they have access to educational supervision and that their educators are aware of their needs and curricula requirements.

*Sharing information of learners between organisations (R2.17)*

- 66** The doctors in training we met were not aware of any specific transfer of information (TOI) about them between the different posts and sites. They confirmed that they had signed a TOI form, but were unable to say what this exactly involves, apart from the supervisors having access to their e-portfolios.
- 67** The educational and clinical supervisors we met confirmed that they receive transfer of information about doctors in training. They receive information from both HEE SW and the medical school, including information on how they can support doctors in difficulty. The trainers recognised that there is no formal transfer of information between different departments within the Trust, but supervisors know how to contact each other to get information about doctors in training. The trainers also said that the e-portfolios are a good way of receiving information about doctors in training.

### 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.*

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

- 68** Year 3 and 4 students at Cheltenham reported generally good educational and pastoral support. Students said they usually get their pastoral support from the student services at the university. Students also feel that the administration staff at the Gloucester academy are sometimes inflexible to their needs.
- 69** Doctors in training told us that if they had any issues, they would go to their educational supervisors in the first instance. All the doctors in training we met said that they receive very good support from their supervisors. One doctor in training mentioned an example when their educational supervisor supported and followed through with the doctor's request for support.
- 70** The senior management team told us that they pay particular attention to supporting learners. The DME, foundation programme directors, specialty tutors and the educational and clinical supervisors all are involved in providing wellbeing and pastoral support to doctors in training. Doctors in training also receive support from professional development tutors, the Ethics and Humanities Tutor, medical education fellows and careers tutor. The DME is also available to be contacted directly by the doctors in training.

**Are working well 2: The Trust provides a supportive environment for doctors in training. We heard of robust structures in place for those with pastoral issues, that less than full time (LTFT) doctors in training are fully supported and that study leave is accessible and welcomed.**

#### *Undermining and bullying (R3.3)*

- 71** All the medical students we met said that they have never experienced or witnessed any bullying or undermining at the Trust. They said that if they noticed anything that they would perceive as bullying they would report it to their unit lead or the academic tutor.
- 72** The doctors in training also did not report any bullying or undermining incidents. They said that the consultants and everyone else in the Trust are supportive and treat them with respect. One doctor in training mentioned that one of their colleagues had experienced some bullying in a cardiology post, but this has been resolved and the doctor in training had now left the Trust. Doctors in training think

that small episodes where consultants might pressurise doctors in training are mostly due to the high level of workload rather than undermining or bullying behaviours.

#### *Information on reasonable adjustments (R3.4)*

**73** The doctors in training and medical students we met had not experienced many situations which required them to request reasonable adjustments. We heard of instances when doctors in training had received some reasonable adjustments during pregnancy. It was perceived by the doctors in training that we met that they have to take the initiative to find information on the reasonable adjustments and need to push for adjustments to be put in place. The trainers we met told us that they usually receive information about doctors in training before they start at the Trust. This means that they are able to deal with any reasonable adjustments required prior to the doctor's in training arrival.

#### *Supporting transition (R3.5)*

**74** The medical students we met said they feel prepared for the transition from student to foundation doctor. The foundation doctors also commented that they feel adequately prepared for their practice.

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

**75** Medical students said that they receive advance information about assessment during their placements. Students gave an example of a presentation they had to prepare for their obstetrics and gynaecology placement and how they were told about it at the beginning of the year and were reminded again closer to the deadline.

**76** Students told us that they feel frustrated that they have to do a large amount of portfolio work during their placements, but this does not contribute towards the end of year assessment. Students commented that they struggle to allocate time between the portfolio work and formative assessments.

**77** The foundation doctors told us they receive sufficient information on their work place based assessments and they know what is expected of them.

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

**78** Doctors in training working less than full time said that the Trust has made adjustments to accommodate them. One doctor in training in emergency medicine said that her department had been very supportive and allowed her to swap non-working days and shifts. The general view amongst doctors in training is that those in less than full time employment are supported. Trainers also confirmed that the Trust has made positive efforts to support less than full time doctors in training.

### *Study leave (R3.12)*

**79** The doctors in training we met said that the Trust welcomes study leave. Foundation doctors always attend their mandatory training. Doctors in higher specialty training and those in core medical training said that the Trust and their supervisors are supportive and try to help as much as they can to allow doctors in training to take study leave.

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

**80** Medical students at Cheltenham told us that they meet regularly with their educational supervisors and receive feedback from them. Clinical supervisors also give immediate feedback on students' clinical skills after completing a task.

**81** Foundation doctors commented that they receive sporadic feedback from consultants on the wards. However this feedback varies through different departments, specialties and from consultant to consultant. In some specialties doctors in training receive good feedback, however doctors training in general internal medicine and gastroenterology perceive this as a weak point. Nevertheless, the majority of doctors in training we met said that they receive some feedback from their educational supervisors through their e-portfolios.

**82** Doctors in training feel that in most cases they receive feedback when they have done something wrong, and they and trainers acknowledge that constructive is a weak point. Doctors in training told us they receive very good feedback from nurses.

### *Support for learners in difficulties (R3.14)*

**83** The educational and clinical supervisors said that HEE SW has issued very good guidance on how to deal with doctors in difficulty which has been very effective. Doctors in training also commented that their supervisors and specialty TPDs are supportive. We heard an example of a doctor in training who had received good support during a period of bereavement.

### *Meeting the required learning outcomes (R3.15)*

**84** The foundation doctors we met said that the onus is on them to meet their required learning competences. They said that although they have regular meetings with their supervisors, most of the assessments and e-portfolio work seems like a tick box exercise.

**85** Doctors in higher specialty training in general internal medicine told us that they struggle to meet their curricula requirements due to workload commitments. They told us that workload prevents them from attending timetabled teaching and having adequate access to educational opportunities. As a result they struggle to complete the hours required in the curriculum for this specialty. Doctors in training said this is has been an ongoing issue for the past two years.

*Career support and advice (R3.16)*

- 86** The doctors in training we met said that careers advice is not very efficient at the Trust and at a regional level. They mentioned a couple of instances when they have struggled to get adequate careers advice from HEE SW. One doctor in training had waited for several months before being able to meet with a representative from HEE SW to speak about career support. At the Trust doctors in training mentioned that they have a good relationship with the specialty programme directors and they have been offering some career advice.

## 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)*

- 87** The educational and clinical supervisors we met told us that they feel supported in their education roles. The trainers are encouraged to complete comprehensive training before becoming an educational or clinical supervisor including modules on equality and diversity, dealing with doctors in difficulty and ARCP training. We heard there are also specialty training sessions available.
- 88** The majority of the trainers have also completed a one day training course on mentoring, coaching and giving feedback. They also attend regular refresher courses from the Colleges. The medical school is also supportive of undergraduate trainers and offers training for their roles. HEE SW also offers training for educational and clinical supervisors.
- 89** The trainers we met had a formal process for appraisal. Those who are involved with undergraduate medical education go through an appraisal process with the medical school. The senior management team told us that the medical director and the DME go through the formal feedback on the trainers' appraisals to identify any areas needing support.

**Area working well 3: Clinical and educational supervisors are well supported in their educational roles by the Trust. They are provided with adequate facilities, selected, trained and funded adequately and they are encouraged to continue their professional development.**

### *Time in job plans (R4.2)*

- 90** We heard from the senior managers, education management team and supervisors that educators are allocated SPAs in their job plans and are paid for their education hours. Trainers also told us that there is an electronic job planning system where they have to record all the clinical hours and the time they spend in their educational roles. However all groups acknowledged that it is a major challenge to complete their allocated hours in medical education. The heavy workload is a major factor that inhibits supervisors to spend the required time in their educational roles.

*Educators' concerns or difficulties (R4.4)*

**91** All the educational and clinical supervisors we met said that they feel supported in their roles by the Trust, medical school and HEE SW. They are confident that they know the pathways and processes for dealing with concerns and difficulties.

*Working with other educators (R4.5)*

**92** We heard in the meeting with senior management that educational and clinical supervisors meet regularly with each other, as well as with TPDs and the DME. The trainers also said that there is ample communication between those involved in education at the Trust. The supervisors are involved in various education committees and have an opportunity to voice any concerns or problems they might have.

**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)*

**93** We heard in the meeting with senior management that undergraduate deans and staff at the Trust are involved in the redesign of the curriculum at Bristol medical school. (See R 2.4 for further details).

*Training programme delivery (R5.9)*

**94** The majority of the doctors in training we met at both sites spoke positively of the overall experience they are having at Gloucestershire Hospitals NHS Foundation Trust and would recommend this trust to others. Doctors in training were pleased with the breadth of training, experience and support they are getting and they are meeting all the curriculum and assessment requirements for most specialties.

**95** Although doctors in training reported a satisfactory level of practical experience to achieve their competences, they also commented that they find it difficult to keep a balance between service provision and their education needs. Doctors in training also highlighted issues with regional and local teaching, with the latter being affected mostly by the heavy workload at the Trust.

<b>Team leader/ Regional coordinator</b>	Dr Richard Tubman Prof Stewart Irvine (Regional Coordinator)
<b>Visitors</b>	Ms Jill Crawford Dr John Jones Dr Katie Kemp Professor Olwyn Westwood Mr Tony Whyte
<b>GMC staff</b>	Emily Saldanha (Education Quality Assurance Programme Manager) Jessica Ormshaw (Education Quality Analyst) Elona Selamaj (Education Quality Analyst).
<b>Evidence base</b>	<p><u>1 – Organogram</u></p> <p>001 (a) Organogram CEO</p> <p>001 (b) Organogram Divisions</p> <p>001 (c) Specialty Tutors</p> <p><u>2 – Quality management framework</u></p> <p>002 (a) Quality Management Framework. Published in January 2016</p> <p>002 (b) Undergraduate and University of Bristol. Published in January 2016</p> <p>002 (c) Undergraduates and University of Bristol. Published in January 2016</p> <p><u>3 - Minutes of two recent meetings held with the medical school or LETB</u></p> <p>003 (a) Deanery 2015 Contract Meeting Minutes. Published in December 2015</p> <p>003 (b) Cardiology Glos Level 3. Published in January 2016</p> <p><u>4 – Risk register(s)</u></p> <p>004 (a) Risk register held by DME recording areas of Concern and Action Plans for them, 3rd version, shared with LETB (previous versions JAN 2015, Dec 2015</p> <p>004 (b) Risk Register held by LETB multiple reiteration</p>

004 (c) Annual Tutors reports summarising risks in their departments, published in minutes with MEB

5 – Equality and diversity strategy

005 Equality and Diversity: An example of how the Trust's Equality and Diversity strategy has furthered the equality agenda. Published in January 2016

6 - Documentation to support the management and monitoring of concerns

006 Notification to the DME of involvement in Trainee Doctors in Complaints, Serious Incidents, Concerns re conduct and legal cases including appearance at Coroner's Court. Published in November 2015  
2<sup>nd</sup> version

7 – Contextual Information

007 LEP Contextual Information request with SWOT report. Document, Published in January 2016 with attachments as below:

Attachment 1 – Trust governance and quality management structure

Attachment 2 – Identifying and managing concerns – case

Attachment 3 – Organisation's relationship with LETB

Attachment 4 – Undergraduates & University of Bristol

Attachment 5 – How the organisation's E&D strategy has furthered the quality agenda.

Attachment 6 – Sharing good practice.

Attachment 7 – Trust wide departmental level changes

Attachment 8 – Background information.