NHS
Health Education England

# Quality Management Visit Outcomes Report

## Derby Teaching Hospitals NHS Foundation Trust

**Visit date: 17th November 2015**

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## 1. Executive Summary

Health Education East Midlands (HEEM) visited Derby Teaching Hospitals NHS Foundation Trust on 17th November 2015. The visiting team encountered a Trust that is committed to providing quality education and training for all healthcare professionals.

The learners and educators we met with were generally positive about their experiences of teaching and training at the Trust, and on the whole learners felt well supported by their educators. Nursing, midwifery and allied health professional students were particularly positive about the support available and quality of their placements in Derby. However, we did identify some areas of concern, most notably in relation to support for Foundation trainees based in Clinical Oncology. The Trust must act swiftly to address these concerns, working with HEEM to identify appropriate solutions.

The visiting team heard about several areas of good practice and innovation, in particular, the work of the specialist palliative care team, who are delivering education and training to colleagues within their own department, across the Trust, and to the community-based workforce. The visiting team was also impressed by the strong educational ethos within the ophthalmology department.

Other areas for improvement, and examples of good practice, are outlined in this report.

We are grateful to all those who participated in the visit and shared their feedback with us.

## 2. Introduction

Health Education East Midlands (HEEM) is responsible for managing the quality of multi-professional education and training across the East Midlands. We have specified the standards we expect providers to meet in *East Midlands Multi-professional Quality Standards for local training and education providers.*

This is the second year of our new approach to quality management visits. This has provided the opportunity to reflect on the Trust's progress since the last visit. It has also enabled us to develop the visiting process to reflect the strengthened relationships between all professions and HEEM

The aim of visit was to look at the quality of education and training of all healthcare professionals within the region. This is to comply with our requirements to improve patient care through the effective management of the quality of healthcare education and training, for both Health Education England and the General Medical Council (GMC). This is a collaborative approach which utilises data from a variety of sources, including the Trust's self-assessment document, the GMC National Training Survey results and workforce intelligence, to inform discussions between HEEM and the Trust about areas of good practice and concern. During a conference call between all key partners the data is assessed and the visit level and specific areas of focus are agreed.

HEEM would like to thank colleagues from Derby Teaching Hospitals who took the time to meet and share their feedback with the visiting team. We are also appreciative of the time taken by colleagues from across the Trust in helping to plan and deliver the visit.

During the conference call it was agreed that, based on the available data, the visit to the Trust should be Level 2. A Level 2 visit means that there are risks to meeting the standards for training and education. This level of visit aims to understand where the risks are and provide support to reduce negative impact on learners and outcomes.

The visit took place on 17th November 2015. The visiting team comprised:

- James McLean - HEEM Deputy Dean of Quality, Education (Lead Visitor)
- Dr Jonathan Corne – Head of School of Medicine
- Dr Bridget Langham – Director of Foundation Training
- Dr Nigel Scarborough – Head of GP Academy (North)
- Mr Stephen Dixon – Associate Postgraduate Dean, School of Dentistry
- Dr Bill Whitehead – Head of Nursing, Diagnostic Imaging and Healthcare Practice, University of Derby
- John Chater – Lay Partner
- Peter Harris – Lay Partner
- Suzanne Fuller – HEEM Quality Manager

- Karen Tollman – HEEM Quality Manager
- Richard Higgins – HEEM Quality Manager
- Naheem Akhtar – HEEM Education Commissioning Manager
- Richard Marriott – HEEM LDA Manager
- Jo Spurgin – HEEM Quality Visit Administrator

Derby Teaching Hospitals NHS Foundation Trust was represented by:

- Sue James – Chief Executive
- Mr Jonathan Allsop - Director of Medical Education
- Dr Nigel Sturrock – Medical Director
- Alison Skinner – Medical Education Manager
- Karen Hill – Senior Nurse (Professional Development)
- Claire Kinnell – Practice Learning Support Manager
- Dr Neil Pease – Director of Workforce and Corporate Development
- Linda Wood – Chief Therapist

## 3. Progress since 2014

Since the last Quality Management Visit in November 2014, the Care Quality Commission have completed an inspection and awarded the Trust an overall rating of 'Good'.

Since the visit last year, a new Director of Medical Education has been appointed. During his presentation we heard that the new DME has engaged with Postgraduate Medical Education Committee, and found this to be a positive experience, with enthusiastic and committed members. The visiting team was pleased to hear that there is patient representation on the committee. We heard that there are strong links between the medical education and workforce teams. For example, we heard that 'listening events' and open surgeries have taken place, which provide an opportunity for junior doctors to provide feedback. Significant work has taken place to develop pro-active communication channels with trainee doctors. We heard that newsletters from the Medical Director have been distributed, with topics including the duty of candor, FGM and antibiotic prescribing.

The Trust has made good progress against most of the areas identified in the action plan following last year's visit. Specific plans have been put in place to provide ultrasound training for trainees in obstetrics and Gynaecology. The Trust acknowledged that they are still struggling with the middle grade rota for paediatrics. There remain concerns in relation to clinical oncology, and these are outlined in the section below.

The Trust provided an update on their balanced scorecards. Overall the Trust are performing well against these indicators. Areas currently rated red or amber include further developing patient involvement in education and training and implementing recognition of trainers across the Trust.

The Trust continues to work towards the GMC's deadline of having all clinical and educational supervisors recognised by July 2016. A robust system for collating data has been developed. The web-based tool used to support appraisal also requires users to provide information about their educational role and whether they are up to date with their training. From April 2016, all educational supervisors will receive 0.1 PA per trainee.

We heard that the Trust have worked with Sheffield Hallam University to develop a mentorship module. This ten credit module, which has been delivered on site at Royal Derby, was well attended and evaluated positively by those who attended. Since last year practice learning support unit has been further enhanced. Two further appointments to the role of Practice Learning manager have been made: the professional backgrounds of these appointments are occupational therapy and Operating Department practitioner. It is pleasing to see that the multi-professional element of this team developing further.

The Trust is working towards the implementation of revalidation for nurses and midwives, with an executive sponsor in place. We have heard from colleagues at other Trusts in Derbyshire that there has been a collaborative approach to this new initiative, and this Trust has been integral to that work. Further information about the Trust's plans for implementing revalidation is outlined in the Showcase section of the report below.

## 4. Medical Assessment Unit

The visiting team met with learners and educators based within the Medical Assessment Unit (MAU). MAU is a busy unit with 51 beds, managing patients referred from General Practitioners and the Emergency Department. Three teams per shift work within the department, and these are led by either a junior doctor or Advanced Clinical Practitioner (ACP). At present, ACPs only work during the daytime.

We heard that the unit had struggled to recruit experienced nursing staff, but had been successful in recruiting newly qualified nurses. There is a preceptorship programme in place to support these new staff members as they transition into practice. In addition to the Acute Consultants based within the department, there are medical trainees undertaking block placements in MAU, and other medical trainees who undertake shifts in the unit. Specialty Consultants also attend the unit to manage patients. There is consultant cover within the unit, from 8am-10pm seven days a week. Consultant cover and the number of middle grade doctors has increased since last year's visit which has strengthened medical cover and helped with managing workload.

There are three 'takes' throughout the day: early, twilight and night. Teams are responsible for clerking the patients that arrive on the Unit during their take. We heard feedback that, while this system appeared to work well for patients, it was not regarded to be as beneficial for junior doctors. We heard that the busiest times on the unit were the twilight shift and around midnight. Whilst increased medical cover was reported to have improved workload, we heard that medical staff do still leave late due to the number of patients they are had to clerk from their take. As the medical staff who are often on duty during this time aren't usually based in the unit full time, it is not clear how data about late finishes is captured.

***Recommendation: MAU should develop a mechanism for recording when doctors, working in the department finish after their shift is due to end, to assess the frequency with which this occurs and at what time of day. This date should include all doctors working within the unit, including those based on other medical wards. This data should be shared with HEEM.***

The visiting team felt there was a strong team spirit among those working in MAU. We heard that the ACP role was valued as a means of bridging the gap between medical and nursing staff. ACPs were able to learn from medical colleagues, and share their own knowledge and experience. It was reported that there were a lot of opportunities for multi-professional discussion, however these were not formalised.

We heard that the rota was well coordinated. We heard that medical trainees based on the unit did not have difficulties in being released for regional teaching. Twice a week there are short, focused teaching sessions for medical staff. Nursing colleagues are able to attend if they wish, however the workload in the department usually precludes them from participating. Separate training is held for nursing staff, and this was reported to be of a good standard.

It was reported that it can be a challenge for medical trainees to receive feedback and on the job teaching about patients they had clerked outside of the day shift. This was in part due to the large numbers of staff passing through the department, including colleagues from medical specialties. Consultant colleagues do encourage trainees at handover to let them know if they would like an assessment to be completed. Whilst it is ultimately up to trainees to be proactive in arranging assessments, the consultant we met with acknowledged that better signposting of opportunities would be beneficial.

Handover was reported to work well, with three formal points of handover throughout the day, using a local tool (known as SHARPS). There is also informal handover of patients throughout the day.

In addition to the Trust corporate induction, learners were provided with an induction to the Unit which was regarded positively. We heard that learners within the department felt well supported and were able to escalate concerns should they arise. Consultants were described as approachable. A student nurse told us she would consider working in MAU once qualified. Learners felt the unit provided a good range of learning opportunities due to the diverse mix of unwell patients.

The educators we met were committed to providing a quality educational experience. However, they reported that much of this activity was based on good will and was not formally recognised within job plans, and it can mean that teaching is done on days off or on an ad hoc basis. We heard that the consultants had good relationships with the junior doctors forum and meet regularly with the college tutor to discuss any issues. We heard that there is a good relationship with nursing staff, who are willing to flag up concerns about medical trainees, should they arise.

## 5. Obstetrics and Gynaecology

The visiting team met with a group of learners and educators based in Obstetrics and Gynaecology. The group included specialty and GP trainees and

student midwives (including some on community placements). Overall the learners were positive about their experiences of working and training in the department.

The medical trainees told us that they had a very good relationships with the midwives based within the department, which they felt was a supportive environment. The department can be very busy with a high workload, and this means it can be challenging to get workplace based assessments signed off. The trainees told us that there are a lot of opportunities to operate and participate in clinics, and they receive a lot of on the job training from consultants. There are opportunities for interprofessional learning, for example during multi-disciplinary team meetings.

Trainees had participated in trust and departmental induction. The trainees felt that further work could be done to ensure that the departmental induction was more focused on information to help them begin work within the department. For example, trainees would welcome the opportunity to shadow. A similar issue was raised by trainees at last year's visit.

***Recommendation: The O&G Department should work with trainees to identify which areas of local induction could be strengthened and ensure it provides information that meets the needs of trainees.***

We heard from medical trainees that due to a lack of sonographers there remained challenges in accessing ultrasound training. This was an issue raised by trainees at the visit last year, and the Trust put in place targeted training to ensure trainees received the training required. However, it appears similar challenges are recurring.

***Requirement: The Trust must ensure that all trainees who require ultrasound training as part of their curriculum are able to access this, and a plan is put in place to ensure this is delivered.***

We heard that there have been some challenges around placement capacity and communication with the University. For example, we heard an example of a community placement where the student was not expected when they arrived. Changes to the midwifery course have also presented challenges for both students and mentors in terms of completing paperwork and signing off students. Mentor capacity has been an issue too. However, we heard that students, once on placement, felt well supported. Students reflected that they felt protected from the day to day pressures of the unit, but were able to access learning opportunities. The mentors that we met with confirmed that there have at times been more students than staff, which can be a challenge to manage. Mentors have had to come in early or stay late to complete paperwork for their students. There has been a huge recruitment drive within the department for midwifery staff. This has been successful, but has presented a tension in terms of balancing the needs of students and preceptors.

We heard from mentors that they are proactive in assessing the competency of students when they arrive with them, particularly for 1st year students: they try not to make assumptions about what a student is able to do as this can be variable.

The consultants we met with told us that they had formal recognition within their job plans for their educational roles. They felt this activity was valued by the Trust.

We heard that there is a box in which staff and students on the ward can anonymously raise any issues they might have. The team was pleased to hear that efforts are made to ensure that students, trainees, and newly qualified nurses and midwives are actively involved in the team and that their respective roles are valued.

Overall, learners felt that the department was very supportive and that there was good team working across professional groups. All would recommend their posts to colleagues and the department to friends and family.

## 6. Dental

The visiting team met with a range of trainees, including DCT 1 to 3 and an orthodontic higher specialist trainee.

The Dental Core trainees attended a Trust induction at the start of their placement in September. The DCT 1s also attended a three day regional induction to the programme. They felt this was useful albeit very clinical.

The Orthodontic higher specialty trainees started in October and so had missed both the main August Trust induction and the September catch-up induction. They had been informed that the next opportunity to attend a Trust induction would be in February, around four months after starting in post. In terms of a departmental induction, the orthodontics trainees had a morning induction on

their first day but were then expected to begin clinical work that afternoon. They felt that this induction could have been extended and the commencement of clinical work delayed as they did not feel as well prepared as they could have been.

***Recommendation: The Trust should ensure that all trainees commencing in the Trust have the opportunity to participate in timely induction that provides them with adequate information about both the Trust and their department.***

Clinical supervision was rated positively by all trainees.

Since the visit last year, the rota has been changed and DCTs no longer work overnight: instead there is a late shift up from 12 noon until 12 midnight. This was seen as positive for the trainees as it avoided the experience of isolation felt overnight, but did provide some exposure to twilight and night time work and the emergency cases which present at these times. After midnight, the consultants are first on-call. This approach appears to be putting significant strain on the consultants, and may not be sustainable in the longer term, and alternative options to support out of hours work, including further engagement with the Hospital Out of Hours team should be explored.

***Recommendation: The Trust should review options for out-of-hours cover for oral and maxillofacial surgery patients, including how the Hospital Out of Hours Team can provide support, to assist in relieving the pressure on consultants within the department.***

Another issue raised last year was around handover, with trainees leaving late after a night shift in order to carry out a face-to-face handover with those arriving for the day shift. The department has worked hard to resolve this issue. This has been addressed to a large extent by the trainees now only working up until midnight. Second, there is now an electronic handover system in place so that it no longer needs to be face-to-face. The trainees reflected that handover had improved since last year but that handover from A&E could be further streamlined.

The trainees' hours have been monitored and were found to be compliant. The trainees were satisfied with this as an accurate reflection of their working pattern. The rotas provide the trainees with plenty of time during the week for administration and audit work (with trainees believing that they would be able to complete audit cycles).

DCTs have protected Thursday lunchtime teaching for an hour. They are also released to attend regional teaching, which they rated positively. The 'Divisional Day' has been cut by the Trust to half a day. The trainers felt that this reduced teaching opportunities because by the time the mortality and morbidity meeting was concluded and other business matters addressed, there was no time left for any other teaching (although the mortality and morbidity meeting was in itself seen as an educational opportunity). Consultants are planning to deliver additional teaching for the orthodontics trainees.

The consultants felt that the current e-portfolio system is not fit for purpose, although it was understood that this might be changing nationally.

The trainees felt that, overall, they were getting a good, well supported clinical experience and that the balance of clinical exposure was better than at the time of the last visit. In particular, the DCT 1s had an appropriate graduated and timely introduction to contributing to lists. DCT 2s welcomed the opportunities to go to Burton for additional clinical experience. A new development from the last visit is that DCTs now have access to orthodontic clinics. The trainees were positive about the library, which they could access 24/7. All trainees would recommend their training posts.

The trainers were aware of Trust plans to introduce the new SPA arrangements for educational supervision from April 2016 and welcomed this initiative to formally recognise trainers and ensure all are appropriately trained for their educator roles.

There is currently no journal club. The visit team agreed with the trainers that this would need to be a trainee-led initiative but, while a positive addition to the teaching which consultants would be supportive of, it was acknowledged that time constraints within the rota might prove a barrier.

Trainees need to be encouraged to make the most of additional opportunities, for example the monthly restorative clinic run by a consultant from Leicester.

## 7. Clinical Oncology

The visiting team met with Foundation trainees working in Clinical Oncology. These trainees are solely based on the wards and do not participate in out-patient clinics.

There is an acute ward round at 10am each day. This ward round covers an average of 6-7 patients who are newly admitted to the ward. This is out of a total of 40 beds. Other patients are reviewed by their own consultant once or twice per week. These reviews do not necessarily happen at fixed times each week, due to clinics and other activity. Registrars attend the ward and review patients when they have capacity between clinics. We heard that this means patients already on the ward could wait several days between senior reviews.

The Foundation trainees participate in a multi-professional board round, which takes place each day. This includes nursing, physio and OT colleagues. The on-call registrars would generally hand over directly to each other, and the Foundation trainees were not involved in this.

The Foundation trainees told us that their access to senior support was variable. There is an on-call consultant covering acute admissions. However, it can be challenging at times to access advice from a patient's named consultant as they are primarily based in clinics, including those which take place at other sites. We also heard that the on-call registrar may too be off site. The Foundation trainees told us that whilst colleagues were happy to be contacted for advice, they could not always get hold of the right person. The trainees told us that the Acute Oncology nurse specialist was supportive and able to provide advice should they need it.

We heard that the Foundation trainees were managing a large number of patients with complex care plans, some of whom were very unwell. They did not feel that they always had access to support in a timely manner and this post did not feel as supportive as other posts they had experienced. In particular, we heard that they often struggled to answer questions posed by patients and relatives about treatment plans, and that they were not always able to get hold of someone who could provide the information requested. We heard that at times this had resulted in the Foundation trainees having 'unpleasant' conversations with relatives who were frustrated by the delay. They also told us that patients might have to wait several days for a senior review, which could potentially delay discharge.

We also heard examples where there appeared to be no planning to cross-cover absences. In one example cited, at the start of the rotation a consultant was on leave for two weeks with no formal arrangement made for cross cover, and at the same time there was no registrar cover for 6 weeks. In this case there was an issue with accessing information about a patient's chemotherapy plan. We also heard that whilst the Foundation trainees are able to leave the ward to attend their Thursday teaching sessions, if the F2 LAS is absent there is no one to cover the ward. We understand that the F2 LAS is due to become vacant at the end of December, with no one identified to fill the post. The trainees also cited an example where a patient had arrived on the ward, but was not formally handed over, and it was unclear from the notes why they had been admitted. This had led to a delay in their treatment.

The trainees told us that they were also struggling to get assessments completed. Whilst senior colleagues were happy to do assessments when they were present on the ward, the infrequency with which they were present made it a challenge. The trainees told us that they were also so busy with ward work that they did not always have time themselves.

The trainees told us that they found this placement to be quite stressful, with limited support available. However, they acknowledged that they had learned a lot and developed their skills, for example in having difficult conversations with patients and relatives.

The visiting team was provided with copies of the handbook and other resources given to the trainees as part of their induction to the department. This included information about oncological emergencies, consent, arrangements out of hours and contact details for colleagues.

The visiting team also met with a group of consultants from Clinical Oncology, including the College Tutor. We heard that, since 2012, the number of consultants within the department has increased to 10, with an eleventh having recently been appointed. It is the intention of the department to put in place a new process called 'Consultant of the Week', whereby one consultant will be present on the ward for a full week. However, it was not clear what the timeframe for implementing this would be. In addition, we heard that 3 specialty doctors have been appointed, with a fourth recently interviewed. The intention is that these doctors will be ward based, however they require further training before they will be able to offer that support. A registrar, who worked in Clinical Oncology whilst an F2, has also recently joined the department.

Whilst there has been a significant increase in the medical staff in the department over recent years, we heard that there has also been a significant increase in the volume of work, and also the complexity, which has absorbed a lot of this extra capacity.

The visiting team discussed with the consultants the concerns regarding support for Foundation trainees based on the ward. This has been an area of ongoing concern for HEEM for a number of years, and a sustainable solution has not yet been implemented. Whilst the trainees felt adequately supported with regard to acute admissions, the visiting team was concerned about the support in place for patients who were already on the ward, in particular in relation to identifying and managing patients whose condition may be deteriorating and timely and effective communication with patients and relatives about issues beyond the competence of an F2.

***Requirement: A plan must be put in place by early December 2015, to provide support to F2s in managing patients on the ward. This plan must ensure that foundation trainees have a clear and consistent means of accessing senior support throughout the week.***

The visiting team explained that without adequate support there was a risk that the F2s could be removed from the department. At present there is a plan for F1s to be placed in the department from August 2016. However, to enable this, HEEM will need similar reassurance that there is appropriate support in place for F1s, including the proposed 'Consultant of the week', and that this is a sustainable solution. It will be vital for all colleagues within the department to support these initiatives in order for it to be effective and maintained in the long term.

***Requirement: In order for F1s to be placed in the department from August 2016, the proposed plan to implement 'consultant of the week' must be in place no later than the end of March 2016, and be sustained throughout the year. This plan must ensure that there is consistent, adequate support for all Foundation doctors based on the ward.***

Since the visit, HEEM have met with colleagues from the Trust to discuss the immediate changes that have been put in place to begin to address the concerns identified. We will continue to support and work with the Trust as they develop a sustainable solution.

## 8. Gastroenterology

The visiting team met with medical trainees (including a specialty trainee, GP trainee and Foundation trainee) and a student nurse based in Gastroenterology. The team also met with educators from the department.

The medical trainees told us that the wards they covered are extremely busy with unwell patients, and can be understaffed. They regularly finish late, often up to two hours after their shift is due to finish. There should be four junior doctors based on the ward, but due to rota gaps this does not usually happen. There is a high turnover of patients within the department, and complex patients referred from clinic often arrive late on the ward. We heard examples of trainees being asked to stay late twice a week to see clinic patients, however they were advised they would not be paid nor get compensatory rest.

The trainees told us that a morning board round takes place each day, and this is usually attended by at least one consultant. Nursing colleagues also participate. However, there are some days when there is no consultant or registrar present. The trainees reported that they would welcome more senior presence on the ward. The consultant we met with reported a different pattern of consultant presence on the ward: we heard from them that there are 3 daily ward rounds that are consultant-led.

The consultants we met with acknowledged that the workload on the wards was very heavy, with unwell patients. They confirmed that often there are only two juniors on duty. They were aware that trainees had on occasions not gone to teaching sessions, to ensure that there is adequate cover on the ward. A long term solution will come once more ACPs have been trained, however, this will take time to happen.

***Requirement: The Trust should undertake a monitoring exercise to assess the frequency and extent to which trainees are working beyond their rostered hours. Following the outcome of this exercise, the Trust should take appropriate steps to ensure that trainees do not routinely stay late and have sufficient support on the ward.***

We heard that Foundation trainees who leave the ward to attend their regional teaching do not have their ward work covered, and are expected to complete this activity after 5pm. The trainees did not feel that the rota took account of the

Foundation trainees being away for an afternoon's teaching once per fortnight. We heard that trainees were working amongst themselves to ensure appropriate cover on the ward: for example GP trainees were co-ordinating to ensure that Foundation trainees were not left alone.

The medical trainees told us that when they covered shifts on MAU they felt welcomed to the unit and part of the team. They said that in contrast to their base ward in Gastroenterology, MAU was a more manageable workload and they were able to get breaks during their shifts. We also heard that there is a perceived lack of clinical support on MAU, so trainees are spending time taking bloods and cannulating, activity which could be carried out by other colleagues. The Trust should consider alternative options for carrying out this activity.

We heard from a student nurse that they were enjoying their placement on the ward. They reported good support from, and access to, their mentor. They told us that they had good learning opportunities and were achieving the competencies required by this placement. They told us that they would definitely like to work at Derby in the future.

We heard from the ward sister that there have been challenges around mentor numbers, and numbers of vacancies, however this was replicated across medicine, and not exclusive to this team. We heard that the Practice Learning Support Unit have been very supportive and come to the ward each week. There is regular contact with University of Derby. Contact is less frequent with Nottingham University, but can access support if required.

We heard that feedback form Speech and Language Therapy students is generally positive. We heard that students do not always have background knowledge of anatomy and physiology when they arrive. This information can help them step into an acute setting much more easily; trainers can spend a lot of time providing this basic information.

## 9. Renal

The visiting team met with trainees based within the renal department. The trainees reported that they had received an induction when they commenced their posts. The induction was felt to provide the information they needed for their roles.

A consultant led morning ward round takes place each day. At 4pm the team meet up to discuss any issues or concerns and handover patients to the next team. Departmental meetings take place Friday lunchtime where various topics are discussed.

The trainees reported that they were able to complete assessments and have these signed off without any difficulties. The trainees that we met with said they felt that they were working in a supportive environment and were enjoying their placements within the department. However, the trainees did report that they did not always get to finish their shift on time.

Trainees reported that they were able to access study leave, even when the unit was short staffed. Study leave for additional activity is also granted when requested.

The trainees were aware that there is a junior doctors' forum which takes place every month. Whilst the trainees we met with had not yet attended this, they were aware that this was a forum in which they could raise any issues or areas of concern.

The trainees felt confident that they would be able to escalate any concerns about patient safety, should such an issue arise. There is a named consultant on duty who would be the first point of contact.

The trainees we met with would recommend the department to family and friends, both as a place to be treated and as place to work and train. Overall, the trainees reported that they were very happy with the training they were receiving in the East Midlands.

The visiting team were taken on a ward round and shown a hub room which trainees can use. We heard from consultants within the department that there is a plan to appoint an anti-bullying champion within the department. The trainers we met with welcome the recognition and remuneration they receive for their educational role, however they told us that they would welcome more opportunities to attend teaching days for their own development.

## 10. Showcase Sessions

### Ophthalmology

Health Education East Midlands has been undertaking a programme review of ophthalmology training across the region, over the past 18 months.

Training in Ophthalmology at Derby has received consistently positive feedback from trainees.

There are 9 consultants, 4 trainees (2 junior and 2 senior), plus 3 Fellows and SAS doctors based in the department. There is further capacity within the department for training but the Fellows are afforded the same training opportunities as trainees and so the department is effectively supervising and training 7 doctors. They try to support the SAS doctors but these mainly provide service.

Derby Royal Hospital is now the site in the East Midlands which delivers the consolidated cataract surgical training model. There is evidence of its effectiveness and other units in the UK are adopting this model of training. With 9 consultants, all sub-specialties are covered.

Trainees are actively encouraged to engage with audit and research and there are opportunities to do this. There is a good programme of departmental teaching and trainees are also released for regional teaching.

The trainees reported that Trust induction was felt to be comprehensive, although could be more engaging. The departmental induction was regarded as comprehensive and effective (this involves half a day induction and a useful booklet).

Clinics are reported to be very well managed so that trainees see an appropriate mix of cases for their stage of training and an appropriate number; there was little indication that trainees are relied upon for service. The needs of trainees are tailored to service opportunities rather than vice versa. The visiting team also heard that handover was good and worked well.

This department has the reputation of being the best in which to train within the East Midlands for Ophthalmology. The visiting team felt that the two key ingredients for the department's success are the efficient management and administration of both clinics and theatres, combined with the consultants' commitment to addressing the needs of trainees. The visiting team felt that there was an excellent educational ethos within the department, which combines good exposure to clinics with appropriate time in theatre. Trainees are also able to participate in teaching opportunities, which are protected from clinical work.

**Specialist Palliative Care Team**

The visiting team visited the Palliative care department, and received a presentation on the range of educational activity offered by the team.

Medical students have the opportunity to undertake a 14 week placement within the department, during Clinical Phase 1. The placement is aligned to their curriculum through blended learning. In addition to teaching from medical colleagues, OT, Physio and other professionals contribute. These placements have been highly rated by students, and the department seeks to act on feedback. It was encouraging to hear that the department is mindful that this could be a medical student's first ever clinical placement, so take care to ensure that they are appropriately supported and that it is an emotionally safe learning environment. Medical students also have the opportunity to undertake a placement in the department in Clinical Phases 2 and 3. The department seeks to emphasise the transferrable skills they can develop and utilise in other areas of clinical practice.

The visiting team also heard about the work of the department to train colleagues from across the Trust to use the AMBER Care Bundle. This is an approach to support clinicians in identifying patients who may be approaching the end of their life. The bundle is being rolled out across the Trust over three years: the final phase is to roll out to surgery and T&O. Colleagues from a range of professions, and level of seniority, including consultants, will be trained. A key aspect of this work is to provide training for junior doctors on writing effective discharge summaries, which will be a valuable transferrable skill.

The team has recently delivered training to community nurses in Derby on end of life care. Initially this was a three day programme for Band 5 nurses, but has also been rolled out to Band 6 nurses. In total, 102 nurses have been trained, and topics covered include communication, symptom control and care planning.

The visiting team was interested to hear that the Palliative Care team is working with local care homes to support enhanced palliative care beds. These beds will help enable patients to stay out of hospital as they approach the end of their life. There are currently ten beds, based in homes which have already been highly rated for their end of life care provision. HEEM will be interested to hear more about this initiative as it develops.

The team has also developed an online resource for health and social care workers in hospitals and the community, where they can access key documents and information about end of life care. There is also information for members of the public. This has been a collaborative project, and will provide a single point of information for those in Derbyshire looking for information about end of life care. We look forward to hearing how this has been used, once the online tool has been relaunched.

## Good Practice Stands

In addition to the sessions described above, the visiting team also observed a number of stands showcasing good practice within the Trust.

### Advanced Clinical Practice

The Trust have been developing the role of Advanced Clinical Practitioner (ACP). The inclusion of an ACP role within medical teams adds a new dimension. The ACP provides the team with an experienced healthcare practitioner who has demonstrated leadership skills that supports the medical and nursing teams within the healthcare setting thus supporting quality care. Once qualified the ACP will be able to work independently thus facilitating the patient pathway. The visiting team were able to meet with ACPs during the visit.

### Growing a Sustainable Workforce for the Future: Clinical Healthcare Apprentices

Derby Teaching Hospitals have developed a vision for Healthcare Support Workers and are growing a sustainable workforce for the future. Apprentices have a positive impact on widening access of opportunity and support aspirations of a younger and more diverse workforce. Twenty Clinical Health Care Apprentices recruited and receive a robust induction programme. There is a comprehensive training plan to ensure standards and consistency and apprentices rotate through departments.

The Clinical Healthcare Apprentice Programme has been so successful that there are plans to extend and develop the model to other groups of Clinical staff, delivering Apprenticeships to Emergency Department Assistants and Pathology support staff. This programme is transferable across all support staff groups and widening participation across Derbyshire would allow other health care providers to join.

### Bereavement Care in Maternity and Gynaecology Services

This stand provided information about the role and responsibilities of the bereavement midwife and link team, who care for families experiencing pregnancy loss and the death of a baby.

Telephone and face to face support services are provided, and the team seek to enhance the environment in which families are cared for. Teaching, guidance and support is provided for the multi-professional team within bereavement care.

In October 2015, the team received a national award for Best Hospital Bereavement Service.

### Hospital Out of Hours (HOOH)

The role of this team is to provide safe and effective clinical overnight care at Derby Teaching Hospitals. The team adopts a multi-disciplinary approach, ensuring tasks are undertaken by the most appropriately qualified person. The team is supported by technology, and use Mobile Medic to support activity. This helps facilitate timely escalation of deteriorating patients and effective communication with ward staff. It also supports improved feedback between the out of hours team and the patient's parent team.

Next steps are to working towards a robust audit tool to continually review the service, and to develop training requirements to support a competency based team.

### NMC revalidation

This stand provided information about the work the Trust has undertaken to support NMC registrants with the implementation of revalidation. Providing support will enable registrants to demonstrate how they continue to be fit to practice as they develop and learn through a culture of sharing, reflecting and learning. This will enable the code of Conduct to be embedded in to the work undertaken; prioritise people, practice effectively, preserve safety and promote professionalism and trust.

As confidence grows in the process of NMC revalidation registrants will feel empowered and progress taking the learning forward.

### Pre-Degree Work Experience for Allied Health Professionals

Building on the success of the Pre-Degree Work experience programme for nursing, the Trust is exploring the potential for a programme suitable for some of the Allied Health Professions. Future plans include to work with Occupational Therapy and Radiography at Royal Derby Hospital and University of Derby to develop and pilot a suitable PDWE programme.

Use of PDWE support roles will support qualified staff in delivering services, particularly in areas experiencing high vacancy rates. PDWE supports values-based recruitment to healthcare careers and by offering this opportunity locally in conjunction with local HEIs, the Trust hope to 'grow our own' future local workforce at DHFT with high quality practitioners.

We are grateful to all those who displayed stands and took time to speak with the visiting team about their work.

## 11. Requirements & Recommendations

**Requirements**

1. The Trust must ensure that all trainees who require ultrasound training as part of their curriculum are able to access this, and a plan is put in place to ensure this is delivered.
2. A plan must be put in place by early December 2015, to provide support to F2s in Clinical Oncology in managing patients on the ward. This plan must ensure that foundation trainees have a clear and consistent means of accessing senior support throughout the week.
3. In order for F1s to be placed in Clinical Oncology from August 2016, the proposed plan to implement 'Consultant of the week' must be in place no later than the end of March 2016, and be sustained throughout the year. This plan must ensure that there is consistent, adequate support for all Foundation doctors based on the ward.
4. The Trust should undertake a monitoring exercise to assess the frequency and extent to which trainees are working beyond their rostered hours. Following the outcome of this exercise, the Trust should take appropriate steps to ensure that trainees do not routinely stay late and have sufficient support on the ward.

**Recommendations**

1. MAU should develop a mechanism for recording when doctors, working in the department finish after their shift is due to end, to assess the frequency with which this occurs and at what time of day. This data should include all doctors working within the unit, including those based on other medical wards. This data should be shared with HEEM.
2. The O&G department should work with trainees to identify which areas of local induction could be strengthened and ensure it provides information that meets the needs of trainees.
3. The Trust should ensure that all trainees commencing in the Trust have the opportunity to participate in timely induction that provides them with adequate information about both the Trust and their department.
4. The Trust should review options for out of hours cover for oral and maxillofacial surgery patients, including how the Hospital Out of Hours Team can provide support, to assist in relieving the pressure on consultants within the department.

## 12. Action Plan

A comprehensive action plan has been received by HEEM from the Trust. The action plan reports the issue and action required. The Quality Manager from HEEM will monitor and support the Trust to produce positive outcomes from this visit.

## 13. Trust Response

The Trust aims to provide a supportive environment for both learners and trainers of all healthcare professions. During the Quality Management Visit, the visiting team were able to meet with trainees and educators from many different professional backgrounds both in their own departments and in the hospital's Education Centre.

The feedback session at the end of the visit was focused and positive and provided useful information with which to begin working immediately.

We are pleased that the visiting team highlighted several areas of good practice and innovation within the Trust and felt that the Trust was committed to

providing high quality education and training. We acknowledge that the team also identified areas where improvements are required. These are set out as 4 requirements and 4 recommendations and we have already started work to make the necessary improvements.

This was valuable review of our educational processes and we thank HEEM for their continued support.