Health Education England

Quality Management Visit Outcomes Report

Chesterfield Royal Hospital NHS Foundation Trust

Visit date: 9th October 2015

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1. Executive Summary

Health Education England, working across the East Midlands (HEE-EM) visited Chesterfield Royal Hospital NHS Foundation Trust on 9th October 2015. The visiting team encountered a Trust that is committed to education and training and is working to develop and refine its own structures in order to ensure high quality. HEE-EM look forward to working in partnership with the Trust to achieve this aim.

The learners and educators we met with were generally positive about their experiences of teaching and training at the Trust. However, we did identify some areas of concern, most notably in relation to arrangements for medical cover out-of-hours in surgical specialties. The Trust must act swiftly to address these concerns, working with HEE-EM to identify appropriate solutions.

The visiting team heard about several areas of good practice and innovation, in particular, the ongoing work to develop the Care Certificate programme for health care assistants. We are keen to work productively with the Trust to share this work with other stakeholders.

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 England, working across the East Midlands (HEE-EM) 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 HEE-EM.

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 HEE-EM 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.

HEE-EM would like to thank colleagues from Chesterfield Royal Hospital 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 9th October 2015. The visiting team comprised:

- James McLean - HEE-EM Deputy Dean of Quality, Education (Lead Visitor)
- Mr Andrew Dickenson - HEE-EM Dental Dean
- Dr Suganthi Joachim - Foundation TPD, Pilgrim Hospital Boston
- Mr Bhaskar Bhowal – Deputy Head, HEE-EM School of Surgery
- Dr Rik Kapila – Quality Lead (North), HEE-EM School of Anaesthetics
- Dr Bill Whitehead – Head of Nursing, Diagnostic Imaging and Healthcare Practice, University of Derby
- Peter Purnell – Lay Partner
- Peter Harris – Lay Partner
- Suzanne Fuller – HEE-EM Quality Manager
- Karen Tollman – HEE-EM Quality Manager
- Simon Mallinson – HEE-EM Quality Manager
- Naheem Akhtar – HEE-EM Education Commissioning Manager
- Jackie Brocklehurst – HEE-EM Transformation and LETC Lead, Nottinghamshire and Derbyshire

- Jo Wallis – HEE-EM Quality Visit Administrator
- Jo Spurgin – HEE-EM Quality Visit Administrator

Chesterfield Royal Hospital NHS Foundation Trust were represented by:

- Dr Iain Dods - Director of Medical Education
- Maxine Simmons – Practice and Professional Development Lead
- Dr Gail Collins – Medical Director
- Gavin Boyle – Chief Executive
- Amanda Rawlings – Director of People and Organisational Effectiveness
- Wendy Ridley – Medical Staffing & Education Services Manager
- Mr Duncan Farquharson – Divisional Director, Surgical Specialties
- Professor Jim Crossley – Associate Director of Teaching, Undergraduate Medical Students
- Steve Hackett – Director of Finance and Contracting
- Bridget O'Hagan – Deputy Director of Nursing

3. Progress since 2014

During the presentation from the Trust the visiting team received an update on specific areas of the action plan from last year. At the quality visit to the Trust in October 2014, the visiting team identified a concern relating to dental core trainees providing cross-cover for the ENT rota out of hours. At this visit, the Trust confirmed that a new surgical rota has been in place since August 2015, which incorporates responsibility for ENT out-of-hours. Dental Core trainees do not now have any out-of-hours component to their work. We heard that a new standard operating procedure is being developed to define the roles and responsibilities of this new rota.

Unsatisfactory information technology systems were also identified at the visit in 2014. The Trust reported that organisation-wide strategy has been developed, and the areas identified will be included as part of a rolling upgrade planned to commence from April 2016.

The visiting team also received an update on the Trust's progress against the balanced scorecard. Work is ongoing to involve the 'patient voice' in education and training. The Trust feel that this is happening in pockets, but more needs to be done to capture this and embed more widely. A draft three year strategy for patient and public involvement across all professional groups has been discussed at the Professional Education Group. HEE-EM looks forward to hearing more about the content of the strategy as it is implemented. We also heard that induction has been strengthened and embedded across the Trust.

The team heard about the challenges around capacity for mentorship. Utilising NMET money, a new model of 'Super-Mentor' is being developed, drawing on the coaching approach articulated in the *Shape of Caring* report. The aim is to deliver a more financially sustainable model which can be implemented, embedded and evaluated.

Learning Environment Managers are being recruited to each clinical area. These roles provide bespoke support to the learners, mentors and trainers in each area. We heard that the aim is to move the Education Team out of the education centre and into the workplace, to support driving up educational quality and capacity.

Clinical educators with a specific focus on undergraduate education have been appointed, using funding from SIFT. We heard there is a recognition that there is a need to develop the relationship with this group of learners in order to secure the future workforce. Medical students from the University of Nottingham will be placed within the Trust from 2016. Clinical educators have also been recruited to support nursing and other professional groups.

The Trust is continuing to work towards the GMC milestone of July 2016 for all clinical and educational supervisors to be trained and recognised in these roles. Work has been undertaken to verify and clarify roles and compile a list of all those who are recognised. This information is being collated, and a specific database has been commissioned to capture and update this information. A blended learning approach has been adopted: online training is available, which is backed up with half-day sessions. These face-to-face sessions contribute to developing a faculty of supervisors within the Trust. Work continues to enhance engagement from the consultant body.

The Trust are also being proactive in working towards the introduction of revalidation for nurses, planned to commence in April 2016. A steering group has been established, and will oversee an

implementation plan, focused around four areas. Communication is a key component of this work to raise awareness and a range of activity has been undertaken already, with more planned over the coming months. A strapline for communications has been developed in conjunction with staff: '*It's your code, it's your revalidation, it's your job*'. Governance is also a priority: for example the Trust are assessing the risks associated with the introduction of revalidation, such as understanding the age profile of nursing staff to gauge whether revalidation will have a significant impact on retention of staff nearing retirement age. Priorities for the group moving forward are identifying and working with those who have an early revalidation date, and identifying and training 'confirmers'.

The Trust has recently undertaken an Educational Resource Group exercise, which reported costs at £1.6 million, which is in excess of income. There was good clinical engagement for this activity across all professional groups, but further refinement of this process is required.

4. Governance of Education and Training

The visiting team met with key personnel from the Trust management and education team to seek reassurance from the Trust regarding engagement with HEE-EM and the governance of education and training, following concerns discussed during the conference call to determine the level of the visit.

The visiting team heard that the Trust has undertaken a critical review of its governance structures. A non-executive director has responsibility for oversight of workforce issues, which would include matters relating to education and is able to provide support. The Trust workforce group meets monthly, with a broader agenda for workforce development and sustainability.

The group acknowledged that traditional structures for the management of education and training were no longer the right model, and contributed to silo working. There were a number of people involved in this area but co-ordination across professions has not happened routinely at the right level, as there have not previously been natural linkages. A new infrastructure is required, but the Trust feels better placed to take these discussions forward, linking with the transformation agenda.

The visiting team discussed with the group the need to develop stronger lines of communication with HEE-EM, not just in relation to where there might be issues, but also to share good practice. HEE-EM are able to support the Trust in developing and showcasing initiatives, but HEE-EM need to be sighted on this activity in order to do so. The Trust team acknowledged that time has been spent 'firefighting' issues locally which may have impacted, but it is important that HEE-EM are aware of this so they can support and work with the Trust to find solutions. Similarly, where local solutions have been identified this can be shared through HEE-EM.

The visiting team heard about a number of initiatives that are at various stages of development, such as developing an ACP Academy and developing other areas of the workforce, such as Radiographers. It is clear that there is a passion within the Trust to develop career pathways for the whole workforce.

The visiting team was pleased to hear that each Board Meeting commences with discussion of a patient story. The team was pleased to meet with enthusiastic individuals, and looks forward to working productively with the Trust over the coming months in an open and productive manner: both in supporting improvements but also to share good practice.

The visiting team suggested that to enable the sharing of good practice, both from within and outside the Trust, and facilitate support to address any areas of concern, quarterly meetings should be established with the multi-professional team at the Trust, and with HEE-EM colleagues from Quality and Regulation, Education Commissioning and the LETC.

Requirement: The Trust must identify the key individuals responsible for the management and delivery of education and training across all professions, and establish quarterly meetings between this group and colleagues from HEE-EM, to monitor progress against areas where improvements are required, and to facilitate the sharing of good practice. Interim updates should also be provided where required.

5. Surgical Specialties

Foundation and GP Trainees

The visiting team met with a group of Foundation and GP trainees based in surgical specialties. The trainees told us that colleagues within the surgical division were welcoming, approachable and supportive. The trainees told us that they had had a

corporate induction at the start of the year, which had been predominantly lecture based. The trainees had also undertaken two days of shadowing. This period of shadowing was reported to be helpful in gaining an understanding of how the wards work. The trainees reflected that a longer period of shadowing would be beneficial.

The trainees reported that clinical supervision in their parent specialty was good during the day. They told us that they had no concerns in terms of meeting their curriculum requirements whilst on this placement. We heard from those based in trauma and orthopaedics that there could at times be practical challenges in getting assessments signed off, or receiving impromptu teaching as senior colleagues were often in theatre.

The trainees told the visiting team that they were concerned about the arrangements for surgical cover overnight. They reported that overnight there is one doctor who is first on-call for five surgical specialties: general surgery, urology, vascular, ENT and T&O. We heard that for general surgery there is a resident registrar available for support, however, for the other specialties there is no one else based at the hospital overnight and at weekends. In some cases, such as ENT, we were told that the next person available to contact was the consultant on-call.

The group felt strongly that at times this system put them in a position where they could be required to work beyond their competence. We heard examples of F1s being called to A&E to provide a specialist opinion on a vascular patient, to determine whether the patient should be transferred to Royal Derby Hospital (who provide specialist vascular services). The trainees told us that in some cases they were covering areas of practice overnight without any induction or introductory teaching about the key issues they will need to manage. In some cases induction to the specialty was not provided until two weeks into their placement, and not before they had undertaken on-call duties.

In addition to concerns about working beyond their competence, the trainees also highlighted the challenges posed in terms of balancing their workload overnight. We heard examples where trainees were being bleeped simultaneously from colleagues within different departments seeking advice and support. This was reported to be in addition to ongoing ward work. In the morning, the doctor on-call then has to hand back to five different individuals who are taking over from them.

We heard that trainees based in T&O have flagged their concerns with consultants within the department, who they understand to have escalated the issue within the division.

We understand that this rota has been introduced since August 2015 and a standard operating procedure is in development. The visiting team is concerned about these arrangements and seeks rapid reassurance that the standard operating procedure provides appropriate guidance and signposts routes of support to trainees on this rota. We will also need to understand how this SOP is communicated to the relevant trainees.

Requirement: The Trust must undertake an urgent review to ensure no patient safety incidents have been reported involving trainees working on the out-of-hours surgical rota since August 2015.

Requirement: The Trust must provide HEE-EM with a copy of the Standard Operating Procedure for surgical care out-of-hours and supporting information about how any risks arising from this approach are mitigated.

Requirement: The Trust must review, and adapt as required, local induction for trainees on the surgical rota to ensure they have the necessary information before undertaking duties out-of-hours within different departments.

HEE-EM will arrange a visit to meet with this group of trainees shortly after the next rotation, and would welcome involvement from the Trust.

HEE-EM has recently completed its programme of night visits to Acute Trusts in the East Midlands. We will work with the Trust to share the learning from these visits which may be beneficial in identifying solutions to the issues raised at this visit.

Specialty Trainees

The visiting team met with a group of specialty trainees based in surgical specialties.

The trainees reported that on the whole they found the training they received to be good and they felt well supported. This was in accordance with recommendations received from peers. The group reported that they had good opportunities for on-the-job learning, and for developing their surgical skills. The group reported that they were covering

the relevant curriculum requirements. The trainees told us that the Consultants were keen teachers.

There were no reported concerns about being released for regional teaching. The trainees based in T&O reported that there was weekly teaching programme run by the registrars, which provided an opportunity to discuss interesting cases. However we heard that in general surgery there is currently no local teaching.

There appeared to be a lack of clarity among the group around routes of escalation as part of the Hospital at Night process, which was described by the group as 'crisis management.'

Recommendation: Share with HEE-EM the most up-to-date Standard Operating Procedure for Hospital at Night, and review how routes of escalation can be clarified and shared effectively with trainees.

The trainees raised with the visiting team their concerns around patients being transferred out of A&E into the Emergency Admissions Unit without them being made aware. The trainees felt that this was linked to pressure to meet the four hour waiting target, and because the surgical team was not aware of the patient, this led to a delay in treatment.

Requirement: The Trust should undertake a review to assess whether there are other incidents where patients are transferred out of the Emergency Department without the relevant team being informed. The surgical division should work with colleagues in the Emergency Department to ensure there is a clear understanding amongst all relevant colleagues, of the protocol for transferring patients to other departments.

We also heard that there was concern around the arrangements for cross-cover for Urology, which is shared with King's Mill Hospital. The trainees described this as not of a good standard, and were concerned about the robustness of arrangements.

Educational Supervisors

The visiting team met with a group of educational supervisors. Unfortunately, colleagues from T&O were unable to meet with the visiting team.

They reported that their job plans recognised their role as educational supervisor. They told us that they received updates from the DME about courses and links to sources of information and advice, which they valued.

The group said that there was a need for greater clarity from training programme directors in terms of identifying who is responsible for clinical and educational supervision at the start of each rotation. HEE-EM will seek clarity from the School of Surgery on this issue and share this information with the Trust once it is available.

The educational supervisors were aware of some of the concerns raised by trainees in the earlier sessions around arrangements for cover out-of-hours. It was felt that there needed to be greater clarity around what is expected and the respective roles and responsibilities. Some of the group commented that they had flagged their concerns regarding cover out-of-hours during the visit undertaken by CQC earlier in the year. The visiting team would welcome the support and in input of educational supervisors from the relevant department as the Trust seeks to address the concerns that have been identified.

The group told us that they faced challenges in delivering the caseload due to the limitations emanating from compliance with the Working Time Regulations, leave and variable emergency admissions.

We heard from this group that historically there have been issues with providing a teaching programme for trainees based in general surgery. However, the group told us that they intend to introduce a planned programme of teaching with immediate effect. A meeting with trainees takes place each month, which is an opportunity for feedback to be shared, and provides the educational supervisors with an opportunity to address any issues that may arise.

Recommendation: The Trust should provide further information about the planned programme for teaching for general surgery, including information about when this will commence and frequency of teaching sessions. We would encourage the department to seek feedback from trainees about the format and content of this programme.

Nursing and AHP Learners

The visiting team met with a group of nursing and AHP students who are on placements in surgical specialties. Overall the learners described a supportive learning environment that was regarded as largely positive.

The group highlighted working in theatres as particularly positive. We heard that there is a 'whole team' ethos, with opportunities for multi-professional learning. HDU was also identified as a good learning experience: this was described as a well-organised placement with a structured training booklet. The Learning Environment Managers (LEMs) were described as being proactive with learners. Clear plans for education are in place which follow patients through the critical care pathway.

We heard that newly qualified nurses felt very welcomed to the ward. Senior team members were identified as taking an active role in welcoming new colleagues. The preceptorship programme was considered to be good. Student learners said that Health Care Assistants and newly qualified staff were particularly supportive of them.

We heard from learners that the workload on the wards could be heavy. They reported that this had impacted on opportunities to access insight visits. We understand that this has been raised with the education team, and whilst they were receptive to the feedback, learners did not feel much had changed yet.

We also heard one reported example of a student learner, who should be supernumerary, being double-counted as both a student and an HCA on the board which records staffing levels. We understand that the student has alerted the Education team to this who are investigating. Whilst none of the other learners in the group were aware of this happening on other wards, HEE-EM would welcome assurance from the Trust that this is not happening elsewhere, and there is an agreed understanding of how students should be included within the headcount of ward staffing levels.

Recommendation: The Trust should provide HEE-EM with assurance as to the steps taken to ensure supernumerary learners are not included within the headcount for safe staffing levels.

Nursing and AHP Mentors and Trainers

The visiting team met with mentors and trainers from surgical specialties. The group told us they felt supported by the Trust and that they had positive relationships with the Higher Education Institutions. They reported that there are opportunities available for inter-professional learning.

The group valued the work of the LEM's as they provided structured support to those delivering education. The visiting team was pleased to hear that the LEMs have protected time to undertake their educational roles. However, the mentors reported that they do not have protected time, and due to the heavy workload on the ward, they will often complete paperwork in their own time. This was a particular issue where mentors were working with more challenging students. The mentors told us they found the document 'Being a mentor: a helpful guide', which has been developed by the Trust, to be useful.

All the mentors that we met felt they could raise concerns with the Universities and Trust Education Team.

The mentors told us they were aware of the forthcoming introduction of revalidation for nurses, and were receiving support from the Trust. The group reflected that further funding would be welcomed for CPD activity, as currently there is limited funding for Learning Beyond Registration. We heard that some mentors had experienced issues with being released from ward work to participate in training. There also appeared to be variation between departments around release for study days, with some allowed more time than others.

Recommendation: Review study leave allowance for mentors and trainers to ensure there is equitable access across all departments in the Trust.

6. Dental and Orthodontics

Dental Core Trainees

The visiting team met with a group of Dental Core Trainees (DCTs). The visiting team were disappointed not to meet with any orthodontic trainees.

The DCTs confirmed that since taking up their posts at the start of September 2015, they do not provide cross cover for ENT. The DCTs work 8am-5pm, with one morning off per week. Sheffield Hospitals provides emergency cover between 5pm and 8pm, when the Trust's Hospital at Night Team take over care for the existing in-patients. As a result of the changes to cross-cover arrangements, DCTs are no longer required to work out of hours.

This is the first year that DCTs have commenced their placements in September, a month later than medical colleagues. The DCTs told us that they have undertaken an online Trust induction package, but

there was no face-to-face element. The DCTs reported that there was no formal ward induction or orientation. We heard that for the first two weeks of their post, the rota had not been confirmed, so the DCTs made informal arrangements between themselves to cover the work whilst the rota was finalised.

The DCTs told us they value the exposure to sedation training that is available from a Staff Grade that works at the Trust one day per week: this was regarded as a particular benefit of Chesterfield. The DCTs run their own out-patient clinics, and can shadow the Consultants' clinics where possible. We heard that the consultants would at time highlight cases that may be of particular interest to the DCTs. The DCTs felt that they were obtaining adequate exposure to minor oral surgery however they did not feel they were getting as much time in theatre as they would like.

The DCTs felt they had adequate supervision and support, although one trainee reflected that there was no 'explicit chain of command'. We heard that the Registrar within the department is supportive, and the DCT3, although new to the Trust themselves, have also been a source of support and advice for the DCT1s. Consultants within the department are regarded as approachable and supportive.

All of the trainees that we met with have a named educational supervisor. They had all met with their ES and undertaken an initial appraisal. The trainees told us that a further appraisal is planned to take place in a few months' time. The trainees have all accessed their e-portfolio and were familiarising themselves with the format. The visiting team emphasised to the trainees the importance of keeping their portfolios up to date and using them to capture reflections on their practice rather than solely relying on log books. The Dental Dean reminded the trainees of the important role portfolios play in recruitment.

At the visit in October 2014, we heard that there were no local teaching sessions taking place, although the DCTs were free to attend Friday teaching sessions in Sheffield. However, their attendance was not monitored. We were encouraged to hear at this visit, that peer to peer study sessions have been suggested by the more senior core trainees in the department, and this has been discussed with the Consultants. The School of Dentistry welcomes this development and will support the Trust, where required, to establish these sessions. The visiting team was also pleased to hear that the trainees will be undertaking ILS training in November, to ensure they are able to continue to support sedation as per the new clinical guidelines.

Prior to the visit, the team were aware of some issues relating to the trainees being released for regional teaching. During the visit the DCTs confirmed that there had been some challenges in obtaining approval to be released, despite the consultants supporting their attendance and clinical work being rearranged to accommodate this. In the session with trainers from the department, we heard that they are supportive of trainees attending regional teaching as they are unable to provide a full local teaching programme within the Trust. We understand from the Trust that there are challenges in releasing all trainees at the same time, however due to the split teaching programmes for DCT1s and DCT 2/3, there are only two occasions in the year where attendance of all trainees is required at the same time.

Recommendation: The Trust should work with the School of Dentistry to ensure that appropriate arrangements are put in place to enable trainees to attend regional teaching sessions.

The trainees all felt that this post was ideal for developing skills in minor oral surgery and oral medicine. We heard that there are also opportunities for those who are interested in orthodontics, such as the joint orthognathic clinic. However, the trainees reflected that it may not be best suited to someone who is primarily interested in maxillofacial surgery due to the lower volumes of this work seen in the department. The visiting team were advised by the trainees that they have been able to accompany one of the consultants to their oncology operating list in Sheffield, which was a valuable learning opportunity.

Dental Educators

The visiting team met with two educators from the Oral and Maxillofacial Surgery department, who deliver training for dental core trainees. The team were disappointed that there was no representation from the Orthodontic team.

The trainers confirmed that DCTs no longer provide cross-cover for ENT. However, this has meant that, given the numbers based in the Trust, it is no longer possible to sustain an on-call rota out-of-hours,

which means that the DCTs no longer undertake any work out-of-hours. It has also had unintended consequences in terms of physical space within the department as all four trainees are on duty at the same time. The trainers advised the visiting team that they are considering reducing the number of DCTs within the department, and potentially converting using the Trust funded DCT post into a Trust grade post. The visiting team are keen to explore with the Trust the option to develop an Oral Surgery specialty training post or Fellowship, as the department appears well placed to deliver this programme.

The trainers we met with were keen to support DCT attendance at the regional teaching provided by HEE-EM. They reported that, with sufficient notice to plan, there would be no issues with three of the DCTs attending teaching at the same time.

The trainers we met with appeared to be unaware of the Trust's plans for the recognition of trainers. However, they reported that they did have time available for educational activity. They understood that the next round of job planning would commence soon, following changes in the provision services at the Trust, and hope that recognition for supervision will be discussed.

7. Emergency Department

Medical Trainees

The visiting team met with a group of medical trainees based in the Emergency Department. The group included Foundation Year 2, Specialty Trainees and an Associate Specialist on a structured programme to achieve a Certificate of Equivalence for Specialty Training (CESR).

The Foundation trainees told us that, whilst the Emergency Department was a challenging place to start the F2 year due to the high pressure in workload, there were a lot of opportunities to complete assessments and develop clinical skills.

The trainees told us that in addition to corporate induction, they had received a helpful local induction to the department, which helped to explain how the department runs.

The trainees told us there are regular Emergency Department teaching sessions for those based within the department. Trainees are actively encouraged to attend teaching sessions when they are at work, and work is managed to facilitate their release. The specialty trainee did not report any challenges with release to attend regional teaching in Sheffield. However, we heard from the Foundation trainees that due to their rota they were not able to attend much of the formal Foundation teaching. An example of only being able to attend 5 out of 17 teaching sessions during this placement was cited, which is below the required 75% attendance. The trainees affected reported that they have been told they are able to count the local ED teaching towards their attendance rate and that the 75% is calculated over the whole year rather than per placement. However, such a low attendance rate will place increased pressure to attend teaching in other posts later in the year.

Recommendation: The Trust should work with the Foundation TPD, to review attendance at teaching for Foundation trainees based in the Emergency Department, and identify solutions to increase attendance.

The trainees described the departmental teaching as good, and it compared favourably to that experienced by trainees in other Trusts. Teaching is usually delivered by consultants or associate specialists. We heard that there is an ethos within the department that 'every day is a school day'. In addition to formal teaching sessions, we heard that plans are being developed to enhance e-learning opportunities within the department.

All the trainees we met with reported that they had a named educational supervisor, and had met with them. The trainees told us that the workload could be constant and was described as 'high pressure' at times. However they said they felt well-supported by their colleagues in the department, and that there were always senior colleagues around to help, so they did not feel they had to work beyond their competence. They told us that at times when a patient may be about to breach the four hour waiting target it could create a tense atmosphere, which some individuals found to be stressful at times. However, they reported that this did not impact on their proposed care plans for these patients. The trainees told us that they did, at times, struggle to get hold of the T&O bleep-holder, with an example cited of a patient waiting 6 hours for a T&O review. However, the trainees felt that on the whole there were good relationships with other colleagues in the department, and they felt empathy towards their colleagues holding the bleep: the Foundation trainees recognised that they may be in this position on a future placement.

The group reported that as colleagues begin and end their shifts at different times in the day, there is no formal whole-team handover: the outgoing doctor in a particular post will handover verbally to the incoming doctor. However, we heard that a new consultant to the department has introduced a board round at 2pm. This is an opportunity for the whole team to get together to review the cases currently in the department. The trainees told us that this was a valuable innovation for the team, as it provided opportunity for peer support, and also had educational value as colleagues could discuss interesting cases.

In addition to the board round, there is also a multi-professional huddle at the beginning of the day. This is an opportunity to share information about what else is happening in the hospital, such as bed capacity, that might impact on the work of the department.

The trainees reported that changes have recently been made to their rota. They have moved from an 8 to a 12 week rota and there is now an additional registrar on duty until 4am, which makes night shifts 'feel fine'. The trainees told us they had asked for an additional registrar-level doctor to help with managing the flow of patients. However, the trainees commented that they still found the rota difficult and described it as 'anti-social' (we heard that trainees worked two in every three weekends), although those trainees who had experience of working in other Emergency Departments did not feel that it was significantly worse than other Trusts'.

The trainees said that they felt this post gave them a good experience of working in a DGH emergency department. For some of the group, this post was their first experience of A&E so it was difficult for them to compare it to others, or say whether they would recommend it. However, they acknowledged that this was an important job that was providing them with a wide range of experiences, and enabling them to build confidence and develop their clinical skills.

Educational Supervisors, Mentors and Trainers

The visiting team met an educational supervisor and some mentors based within the Emergency Department.

The Educational supervisor told us they felt well supported by the Trust education team, local Training Programme Director and School Board. They described good engagement from other colleagues in the department: all but one of the seven consultants are educational supervisors. They all have time within their job plan for this activity. The ES reflected that they would welcome more time for 1-2-1 teaching, as there is currently limited capacity to undertake extended supervised learning events (ESLE).

We understand that the department is seeking to appoint an 8th consultant, with the long term aim of reaching 10 consultants

The ES explained that local teaching had recently been moved from Thursdays to Tuesdays, to avoid clashes with regional teaching sessions. It was reported that this has facilitated higher attendance at the local sessions. In addition work is ongoing to use the Virtual Learning Environment to support e-learning for trainees and supplement local teaching.

The visiting team was pleased to hear about plans to develop a GP Fellowship post, for a post-CCT GP trainee. The vision is for this post to be split between A&E and general practice, which will enable the sharing of knowledge between the two clinical environments. The department is working with HEE-EM and commissioners on this idea. We look forward to hearing more about this innovation as plans develop.

The mentors told us that there were good opportunities for multi-professional learning within the department including opportunities to facilitate trauma teaching, and access to develop skills such as cannulation and ECG.

We heard that the Clinical Educator in the department will be supernumerary. This is to enable them to provide support to the relatively large numbers of new, and newly qualified staff nurses taking up posts within the department.

The mentors reported that there were increased numbers of staff within the department, which was welcomed, but there was also an increase workload.

As with other departments, mentors did not have dedicated time for their educational role and tried to squeeze in the completion of paper work at the beginning of the day shift or at the end of the night shift.

8. Critical Care

Learners

The visiting team met with a group of multi-professional learners based in the critical care department. The group was very positive about their experiences at the Trust.

Across medical, nursing and AHP learners, all described a highly supportive environment in which to train. Learners described a strong team ethos that was inclusive. Colleagues within the department were described as approachable.

Both medical trainees and student learners told us that they had a thorough induction at the beginning of their placement, which was helpful in providing the information required.

The medical trainees in the group described an inclusive approach to decision making, which they particularly valued. The trainees felt that they had good levels of supervision, although reflected that at times this could be too direct and there may be times where supervision could be somewhat 'more distant'. There was some dissatisfaction with their fixed rota, but not with all trainees.

We heard that the Clinical Educator role had been very beneficial to the team and brought structured learning and formal training processes for new staff within the department. Additional learning opportunities are also available and supported.

We heard examples of multi-professional learning taking place within the team: mandatory training is completed jointly, and the Recognition and Management of Critically Ill Patient (RAMSI) course had been delivered jointly to medical and non-medical colleagues within the department. The learners also reported that an inter-professional 'Let's Talk Care' session had taken place within the department.

Educators

The team met with a group of multi-professional educators from the Critical Care department. They described a close team which works well together to create a positive learning environment.

The visiting team heard that nursing mentors have support from the Trust's Learning Environment Managers (LEMs) who have protected time to work with students and mentors in the department. In particular they have provided support to new members of staff. This was described as being 'very beneficial' to the team. Newly qualified nurses will spend four weeks working as supernumerary as a minimum and this can be extended on an individual basis if needed.

The medical educators explained that the local survey, undertaken by HEE-EM School of Anaesthetics, has produced positive results from trainees within the department. The trainers feel that there are further educational opportunities that could be developed, particularly in the Intensive Care Unit, and are keen to explore with the School of Anaesthetics options for accommodating more medical trainees within the department.

CQC visited to the Trust earlier in 2015, and their report requires the Critical Care team to provide an outreach service and take on responsibility for HDU. We heard that to deliver this it was felt that another tier of on-call would be needed. Consultant expansion to deliver this is currently being negotiated. Other options, such as the use of physician associates or staff grades, are being considered. We would urge the Trust to be mindful of the impact on trainees when reconfiguring services, and to ensure current learning opportunities are not lost and potential new opportunities are identified.

9. Showcase of Good Practice

Care Certificate

The Practice Learning Lead presented the work they have undertaken to develop a care certificate.

The Care Certificate, implemented in April 2015 has been built up from an earlier programme for health care assistants. It is embedded within the development framework for support staff and helps to enable career progression amongst this group. It is a nine day taught programme based around 15 core standards. It is linked to a level 2 diploma, and mapped to the apprenticeship framework. Assessment in practice is a key element. All new support staff who join from outside of the Trust undertake the certificate, but this training is also open to current staff.

Care certificate supervisors must have two years' experience in a care setting and must demonstrate the right values and behaviours. They undertake a 2

day in-house programme. Assessment is undertaken via portfolio.

80 new staff have commenced on the programme since June 2015, with seven having fully completed. 44 individuals have been approved as care certificate supervisors.

Early feedback has been positive from both support staff and supervisors.

Inter-professional simulation in the birth centre

The visiting team was provided with information about a recent multi-professional simulation undertaken in the birth centre: the exercise simulated a major obstetric haemorrhage. Such a clinical scenario requires input from differing groups of staff. The aim of the simulation was to take a whole system approach to learning and testing out relevant policies across the hospital. Real-time activity was undertaken during the course of the simulation. In addition to clinical staff, there was involvement from a lay representative and colleagues from the blood bank.

Key learning points from the simulation were identifying the need for clear leadership and the importance of communication across groups.

Clinical Educators

The visiting team received an update on the new Clinical Educator roles that have been rolled out across the Trust. There are currently four in post, across the medical and surgical divisions. Feedback from staff had indicated that students were moving on from the Trust due to a lack of support. These roles are supernumerary to ward staffing numbers, and thereby provide a dedicated resource for supporting education and learning.

A network has been set up across the Trust to share experience and support and help to identify potential opportunities.

Key measures for the success of these roles are improved retention and decreased sickness absence levels, as well as analysis of reporting of incidents via the Datix system, complaints and disciplinary action.

The role of the clinical educator was summarised as being someone who can facilitate, empower, enable and support learners and mentors. They will also play a role in recruitment.

Certificate of Equivalence of Specialist Registration (CESR)

The visiting team heard from a consultant based in the Emergency Department and the work they have been undertaking to support doctors at Associate Specialist level through the CESR programme. This initiative enables staff grade doctors to achieve consultant level outside of a formal training programme. The Trust has adopted the model used successfully by colleagues in Derby.

A bespoke programme has been developed, and three posts have now been filled. The doctors spend 8 months based in the emergency department and a further four months in another chosen area. The doctors are provided with educational supervisors to support their learning and development. The increased numbers means there is more cover on the middle grade rota. In addition to clinical duties, these trainees also receive one day for study.

Emergency Department Induction Video

The visiting team viewed a video that has been developed to support trainees working in the emergency department. The video is aimed at those doctors who are based in other specialties who may be called to work in the emergency department whilst on-call. The video provides trainees with a succinct introduction to the key information they will need to be able function effectively whilst in the department. It is shown as part of the formal induction to the Trust, but is also available for viewing via YouTube, afterwards.

In addition to the formal presentations, the visiting team also viewed a number of stalls showcasing good practice across the Trust. Areas of work showcased included the Trust’s approach to revalidation for nurses, induction resources for new members of staff, clinical skills teaching and simulation. We are grateful to all those who took time to display their work and speak with the visiting team.

10. Requirements & Recommendations

Requirements

1. The Trust must identify the key individuals responsible for the management and delivery of education and training across all professions, and establish quarterly

meetings between this group and colleagues from HEE-EM, to monitor progress against areas where improvements are required, and to facilitate the sharing of good practice. Interim updates should also be provided where required.

2. The Trust must undertake an urgent review to ensure no patient safety incidents have been reported involving trainees working on the out-of-hours surgical rota since August 2015.
3. The Trust must provide HEE-EM with a copy of the Standard Operating Procedure for surgical care out-of-hours and supporting information about how any risks arising from this approach are mitigated.
4. The Trust must review, and adapt as required, local induction for trainees on the surgical rota to ensure they have the necessary information before undertaking duties out of hours within different departments.
5. The Trust should undertake a review to assess whether there are other incidents where patients are transferred out of the Emergency Department without the relevant team being informed. The surgical division should work with colleagues in the Emergency Department to ensure there is a clear understanding amongst all relevant colleagues of the protocol for transferring patients to other departments.

Recommendations

1. The Trust should work with colleagues in the general surgery team to develop a plan to deliver local teaching for general surgery trainees.
2. Share with HEE-EM the most up to date Standard Operating Procedure for Hospital at Night, and review how routes of escalation can be clarified and shared effectively with trainees.
3. The Trust should provide further information about the planned programme of teaching for general surgery, including information about when this will commence and frequency of teaching sessions. We would encourage the department to seek feedback from trainees about the format and content of this programme.
4. The Trust should provide HEE-EM with assurance as to the steps taken to ensure supernumerary learners are not included within the headcount for safe staffing levels.
5. Review study leave allowance for mentors and trainers to ensure there is equitable access across all departments in the Trust.
6. The Trust should work with the School of Dentistry to ensure that appropriate arrangements are put in place to enable trainees to attend regional teaching sessions
7. The Trust should work with the Foundation TPD, to review attendance at teaching for Foundation trainees based in the Emergency Department, and identify solutions to increase attendance.

11. Trust Response

The Trust would like to acknowledge the findings of the report and thank the HEE-EM visiting team for their professionalism during the visit.

The Trust is committed to the education; training and development of all our staff to support our goal to become an ‘outstanding’ CQC rated hospital in 3 years.

We are pleased that the team noted the significant progress that has been made over the last year in many areas and that there are many examples of innovative and exemplar practice that will be shared with other providers across the East Midlands.

We also recognise that there are areas that require improvement as a result of service changes and underfill of training posts. These issues were highlighted in our local discussions prior to the visit and mitigations were in the process of being implemented. Further work is underway to redesign the rota of the junior doctors in surgical services to ensure clarity of referral pathways and defining roles and responsibilities of members of the team. This will ensure a safe environment for delivering patient care and learning.

We have produced an action plan with lines of accountability and timelines to ensure we meet the requirements of the report. Compliance with the action plan will be monitored through our Quality Delivery Group and Workforce Planning, Education and Development Group. A non-executive board member has been identified to lead on education and training.

We look forward to continuing our partnership with Health Education England – East Midlands in developing a healthcare workforce adaptable to the needs of the population we serve.

Dr Iain Dods
Director of Medical Education
on behalf of Chesterfield Royal Hospital