NHS
Health Education England

Quality Management Visit Outcomes Report

University Hospitals of Leicester NHS Trust

Visit date(s): 12th & 13th November 2015

Developing people for health and healthcare

www.hee.nhs.uk

THE NHS CONSTITUTION
the NHS belongs to us all

1. Executive Summary

Health Education England, working across the East Midlands (HEE-EM) visited University Hospitals of Leicester NHS Foundation Trust (UHL) on 12th and 13th November 2015. This was a level two visit, denoting medium risk. There were no serious patient safety concerns. In general, learners felt well supported by their trainers / mentors and reported good education and training being in place.

There were, however, significant concerns about the delivery of education and training within the Cardiology department at the Glenfield Hospital, where the delivery of postgraduate medical education and training is failing to meet local and national standards. There is evidence that this has been the case for at least eighteen months. On-going efforts to improve quality have been unsuccessful. Reputational damage poses a risk to recruitment and retention of the future workforce and therefore to the Trust and to HEE-EM. Significant improvement will be required within a relatively short period of time for HEE-EM to continue to support Cardiology training within UHL. However, consultants have insight into the challenges, with a clear commitment at Trust and departmental level demonstrated to initiate change. HEE-EM will re-visit the department in early 2016 with external input. An immediate priority needs to be the provision of senior clinical input and daily supervision to all of the inpatient areas.

The quality of postgraduate medical education and training within the Emergency Medicine department remains high. The sustained quality is impressive given the considerable service pressures. However, the handover and transfer of patients between A&E, acute admission areas and inpatient wards seems disorganised, which poses a potential risk to patient safety as well as impacting on training opportunities.

There have been considerable improvements to the quality of education and training achieved within Anaesthetics since the last visit. The progress has exceeded HEE-EM's expectations.

In general, education and training governance and quality control structures are strong and there was evidence of a positive impact. The Trust was also able to demonstrate the effective utilisation of non-medical tariff funding.

2. Introduction

Health Education England, working across the East Midlands (HEE-EM) is the vehicle for providers and professionals, working as part of Health Education England (HEE), to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public. HEE-EM has developed a set of multi-professional education and training standards, based on those published by national regulators, such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). HEE-EM visits all local education providers (LEPs) on an annual basis and uses these standards to assess the quality of education and training provision. LEPs can use the standards for internal quality control and for assurance that they are delivering high quality education and training.

This is the second year that HEE-EM's visits have not just focussed on postgraduate medical education and training, but have looked at the learning environment as a whole by taking a multi-professional approach and meeting with a range of non-medical leaners and their mentors / supervisors. The visits have provided an opportunity to assess progress since the last visit, to be appreciative of good practice, and to identify any areas for improvement.

HEE-EM takes a collaborative approach to organising its visits. Data from a variety of sources, including Trusts' self-assessment documents, the GMC's National Training Survey results and workforce intelligence are utilised to inform discussions between HEE-EM and Trusts about areas of good practice and concern. During a conference call between all key partners these data are assessed and the visit level and specific areas of focus are agreed.

During the conference call for the visit to UHL, it was agreed that, based on the available data, a level 2 visit would be undertaken, signifying medium risk. It was decided that HEE-EM would visit both the Leicester Royal Infirmary (LRI) and the Glenfield Hospital over two days (12th and 13th November 2015). Agreed areas of focus were:

- The Acute Medical Care pathway (including Accident and Emergency, Acute Admissions areas and base medical wards);
- Cardiology;
- Respiratory medicine;
- Anaesthetics;
- Small surgical specialties (including ENT and Plastic Surgery);
- Dental training.

The Trust also organised a session to showcase good practice and innovations for improving the quality of education and training.

HEE-EM would like to thank the Trust for its engagement with this process, evident by the attendance of the Chief Executive and other members of the senior team during the opening and closing sessions. This report details the outcomes of the visit and makes recommendations and requirements where areas for improvement were identified.

3. Progress since 2014

The Trust continues to make good progress in a number of areas.

Quality Improvement and Educational Governance

There is a continual quality improvement project and, since the last visit, the Trust reports that most indicators are moving in the right direction.

A medical education strategy is in place and the Trust is in the process of developing a multi-professional strategy.

The Trust is investing in a simulation suite at the LRI to enhance learning opportunities.

A multi-professional education facilities strategy was presented to the Executive Board in November 2015.

Medical and non-medical leads are working together on the development of simulation training.

Clinical Management Group (CMG) Education Leads are developing local action plans to improve the quality of education and training and the Trust recognises the benefits of intervening proactively in areas of concern before these are escalated to HEE-EM and/or regulators.

There is regular reporting on education and training to the Executive and Trust Board and education income is now clearly visible (for example, within CMG budgets).

Service Reconfiguration

The Trust has entered a period of major service and estates reconfiguration and organisational change. The Trust proposes to move from three sites to two (the Leicester Royal Infirmary and the Glenfield Hospital), with the Intensive Care Unit (ICU) and dependent services moving from the Leicester General Hospital to the LRI and the Glenfield Hospital. There are other major moves such as maternity services moving to one site at the LRI. The new Emergency Medicine Department is also under construction and will impact on how acute medical services are delivered. These changes are complex and need to be carefully managed. The Trust is fully aware of the need to be mindful of the impact on education and training and these considerations are being taken into account, although implementing change while maintaining both service and education is complex and challenging.

An example of the importance attached to education and training when change is proposed is that all business cases are now required to include educational implications.

Developments in Postgraduate Medical Education

There is increasing recognition that the non-training doctor workforce is crucial to the trainee workforce, and that these doctors need to be supported. For example, all Trust grade doctors are now allocated educational supervisors.

There is ongoing commitment to improve trainee engagement, with a well-established doctors-in-training committee. Other reporting mechanisms have also been developed such as the online 'Gripes' tool for feeding back concerns and including representation from trainees on key Trust committees.

Rota gaps continue to pose a significant challenge to the delivery of high quality education and training. The Trust is working hard to fill these gaps and mitigate risks through international recruitment and Physician Assistant roles. There are also plans to create a Physician Associate Programme in partnership with DeMontfort University (DMU) and the University of Leicester, with the aim of this commencing in September 2016.

Multi-professional Education and Training

An increase in the number of pre-registration nursing students has been accommodated by the Trust.

New non-medical learning opportunities are being developed (for example, an Advanced Practitioner Module is being commissioned from a HEI provider as part of an MSc programme). UHL is also working in partnership with Leicestershire Partnership NHS Trust in the delivery of an Assistant Practitioner education and training programme.

UHL has around twenty-five dual registration nursing students, whom it is keen to retain and identify career opportunities for. How to address challenges in taking this forward will need to be carefully considered and there will need to be input from all stakeholders.

Support for students who are returning to training following significant gaps has been developed.

A rotation programme between UHL and Leicestershire Partnership Trust has been created to better support new graduate nurses and therapists.

HEE-EM shares the Trust's concerns about high levels of attrition, especially among 'Widening Participation' students, in nursing and also in mental health nursing.

In the Balanced Scorecard, the Trust highlighted that there is a risk to meeting the standard around 'Recruitment and Evaluation' (which is now on red) as the results from DMUs' student placement evaluations are not being shared. As a result, UHL is developing its own placement evaluations.

The Trust has noted that regular, tripartite meetings involving HEE-EM, HEIs and Service seem to be in abeyance. The Trust found these very helpful and would welcome their reintroduction. HEE-EM's Quality Manager for Leicestershire will feed this back to the Education Commissioning Team. The Trust had also found the HEE-EM Tariff Group useful. This was a regional group established at the time of implementing the new tariff and it has subsequently ceased following implementation. However, HEE-EM is looking into re-establishing the group subject to any national changes around undergraduate student funding arrangements.

Recognition and Approval of Trainers

The Trust is approximately 75% compliant in terms of identifying all of its trainers and ensuring that they are trained for their roles, but this figure is probably an overestimate as the Trust feels that there are those undertaking educational roles who remain unknown to it. MedWise is an online educational supervision training resource, which will be used by many to undertake the training they require for their role. The system will produce monthly reports on those who have completed modules by Trust, which should help to identify trainers who can be approved for the role.

4. Sessions

Trainees and Trainers in Emergency Medicine

Following serious concerns raised in 2012, the Emergency Medicine Department, supported by the Trust and UHL, achieved significant improvements in the delivery of postgraduate medical education and training. This included protected teaching, on-the-job feedback and support for assessments. Despite initial reservations about the sustainability of the improvements given the high service pressures faced by the department, follow-up visits over the last two years have shown that the improvements have remained in place. This visit provided an opportunity to again monitor the quality of education and training within the wider context of the acute medical care pathway.

The visit team met with a number of trainees, including Foundation Year Two (FY2) trainees, GP trainees, core level trainees and Higher Specialty Trainees (HSTs). The team then met with trainers within the department in a separate session.

From the feedback received, HEE-EM is extremely impressed that the department has managed to maintain high quality education and training provision for all postgraduate medical trainees despite an almost unprecedented increase in service demand. When working in clinical areas, the trainees reported receiving a high level of informal, constructive feedback and a good balance of exposure to majors and minors. Trainees are released to attend regular department teaching, which is protected and rated highly, and also to attend regional teaching (including Foundation and GP teaching). Despite the heavy workload within the department, trainees reported being able to leave on time and did not feel that service was impacting negatively on training. While core level trainees find completing ACATs a challenge (which is the case in many other departments and Trusts),

on the whole, trainees felt able to complete their required assessments. This is mainly due to the proactivity of consultants making themselves available to trainees (for example, through CBD clinics).

No patient safety concerns were raised by trainees and they felt very well supported by seniors at all times, including in Paediatric A&E. Departmental induction was rated positively and handover regarded as both safe and educational.

In general, the trainees would recommend the department as one in which to train. Moreover, their experience had led some trainees, particularly at a more senior level, to want to work in the department in future, so the department's hard work appears to be paying off in terms of developing the future workforce.

It was clear to the visit team that consultants within the department are protecting and 'shielding' their trainees from the intense demands of service in order to maintain a high quality learning environment. HEE-EM worries about the sustainability of this as the consultants are, as a result, under enormous stress and pressure to maintain service while carrying a heavy supervision workload. HEE-EM understands that there are key roles vacant relating to the delivery of training, which are being covered by consultants beyond their existing job plans.

The visit team was told that the department is funded for 26 whole-time equivalent (WTE) consultants but that there are only 12.8 WTEs in post and that effectively 8.2 WTE consultants are covering a 16 person on-call rota. This is compounding the situation. However, the new Emergency Department build should help with patient flow and, if the HSTs expressing an interest in staying in Leicester can be recruited as new consultants, this should help to fill vacancies. Nevertheless, UHL needs to monitor the situation due to the risks to the sustainability of improvements in education and training. The Trust also needs to support the consultants in their work as they continue to make very effective use of, and maximise, the resources available to them, and as they continue to innovate despite the service pressures.

Non-medical learners in Emergency Medicine, acute admission areas and a base medical ward

The team met with a range of learners on placement in the Emergency Department. Disciplines represented were nursing (including advanced practitioner training), dietetics, physiotherapy, pharmacy, radiography and occupational therapy.

Student nurses reported variable placement experiences (although they were not just reflecting on UHL), with the quality heavily dependent on mentor support and commitment. They noted that mentors needed protected time for their role and, in some cases, greater familiarity with the assessment documentation. Nevertheless, their overall experience was positive. Students training in radiography, pharmacy and occupational therapy reported very good support and opportunities for learning.

The trainee Advanced Practitioners' experiences were more mixed. The role is very new and there was a sense that they are 'blazing a trail'. They attend the FY1 teaching programme but felt that this was not always appropriate for their level of experience and would like the opportunity to attend Core Medical Training (CMT) teaching instead. There is no consultant PA time to support the Advanced Practitioners and they reported that links between UHL and DeMontfort University were poor. They specifically highlighted the importance of being given access to SystmOne as an aid when clerking patients, which was currently unavailable to them.

Recommendation: Explore the appropriateness and practicality of trainee Advanced Practitioners attending CMT teaching rather than FY1 teaching.

Recommendation: Look at whether Advanced Practitioners can be given access to SystmOne.

In general, there was near unanimity among the group of leaners in the session that they would definitely recommend UHL as a placement setting to fellow students.

Non-medical mentors / supervisors from Emergency Medicine, acute admission areas and a base medical ward

The team met with mentors / supervisors from pharmacy, dietetics, occupational therapy, physiotherapy and radiology, as well as Practice

Learning Leads (PLLs). The mentors and supervisors were enthusiastic and generally felt well supported in their roles by the Trust. They recognised in particular the importance and improvements which had followed the introduction of the practice facilitator roles. All were aware of the non-medical tariff and recognised its usefulness in supporting education. They felt well supported by the university overall.

They suggested some improvements, including:

- More information for associate mentors around their role;
- Additional space, particularly for confidential discussions with students;
- Development on new types of placement, for example across sectorial boundaries to reflect new ways of working;
- Better liaison with Higher Education Institutions (HEIs) around documentation, especially when changes are introduced.

Recommendation: Reflect on the suggested improvements made by the mentors and supervisors to see if any changes can / need to be made.

Trainees and trainers from base medical ward and acute admission areas

The team met with trainees from a range of training grades (FY2 to ST7) working in acute admission areas, including the Acute Frailty Unit (AFU), ward 34 – a short stay ward, the Acute Medical Clinic, and Admission wards 15 and 16. There was also representation from a base medical ward – Rheumatology.

The general impression gained was of a highly variable quality of education and training being delivered and in trainees' day-to-day experiences. Education and training was impacted on by service and rota gaps (although the trainees did appreciate that the Trust had attempted to recruit staff grade doctors). Also, the quality of on-the-job consultant supervision and teaching seems to be dependent on who the trainees work with (in terms of consultants and more senior doctors).

When staffing levels were low, trainees reported feeling that clinical areas felt unsafe, particularly on the AFU and ward 15 (which was described as being a 'holding area').

Trainees reported still having to work 'discharge shifts', which are of little educational value. This was highlighted as an issue during the March 2012 Quality Management Visit and the Trust confirmed by the end of that year that rotas had been reconfigured and this issue addressed.

Requirement: HEE-EM requires confirmation as to whether medical trainees are required to undertake shifts / weeks where they are only discharging patients and, if this arrangement is still in place, how frequently it occurs and how the impact on education and training is taken into account.

The LRI is a large hospital and, with multiple acute admissions areas, the acute medical pathway is complex. As on previous visits, trainees perceived handover arrangements to be variable and at times chaotic. This reflects HEE-EM's observations of an evening medical handover during a recent night visit. Again, there were concerns that patients are sometimes transferred from acute admission areas to wards without the knowledge of the trainee dealing with that patient (and while they may be in the process of awaiting test results). There was a perception that nurse to nurse transfer of patients often takes place.

Trainers assured the visit team that there is clinical oversight of patient transfer, which trainees may not always be aware of, but recognised that handover and transfer of patients is an area that needs to be strengthened. Current arrangements are at best variable and inconsistent, and the visit team was not reassured that there is no risk to patient care within the current system. In particular, trainees were concerned that arrangements on ward 15 meant that patients with high early warning scores may not be seen in a timely manner.

HEE-EM cannot permit trainees to train in environments where there are patient safety issues so needs to be reassured that this is not the case.

The trainees provided a number of ideas about how to improve handover and were keen to help to deliver improvements. Meanwhile, the trainers agreed that this should be an area of focus. HEE-EM welcomes this commitment to change, and consultants and service leads should involve trainees to harness their enthusiasm to help make quality improvements.

Requirement: Handover and the transfer of patients needs to be more robust across the acute medical care pathway at the LRI for both patient safety and educational resources.

There was, however, also positive feedback from trainees. They felt that, in general, UHL provided better exposure to acute medicine than other hospitals (particularly when working nights). They also described consultants on the whole to be approachable and supportive. They were appreciative of the Trust's attempts to fill rota gaps and did not feel pressurised into doing so themselves. They felt that the increase in staff grade doctors had made a positive impact on training opportunities. While the visit team did have some concerns about risks to patient safety based on what was heard, trainees reported feeling able to raise concerns and gave examples of when they had done so and how these concerns had been addressed. The Thursday HST led teaching was regarded as good and trainees were able to attend their GIM regional teaching.

A suggestion from the trainees, which could feed into the improvements required for cardiology (see below), was for ACCS trainees to spend some time in cardiology at the Glenfield Hospital to improve their knowledge and confidence around cardiac cases.

Cardiology at the Glenfield Hospital

The visit team met with trainees and trainers from Cardiology at the Glenfield Hospital and there was an opportunity to visit clinical areas. A presentation was also given on the delivery of education and training within the department. In addition, members of the visit team spoke to non-medical learners on placement within the department as well as their mentors / supervisors.

Cardiology had been a focus for the 2014 Quality Management Visit some twelve months prior and a number of areas for improvement were identified. A key one was the level of senior support and supervision provided. HEE-EM elected to visit cardiology again due to concerns about progress on making improvements.

For Foundation and Core level trainees, senior support can be provided by both consultants and HSTs, although some regular consultant input should be expected. For HSTs, senior support is provided by consultants. Foundation trainees described variable senior supervision in terms of frequency and quality both in and out of hours. It was reported that there are some days where no senior patient reviews take place and that senior trainees are under pressure to undertake clinics. The trainees did, however, describe some early signs of improvement in supervision on ward 28, with the appointment of additional consultants.

Morale among the HSTs seemed to be low. Several HSTs met with the visit team and all were disillusioned by their experience in the department and would not recommend it as a place in which to train. They spoke of a poor reputation the unit has nationally among trainees as a training location and all reported having a better training experience in district general hospitals within the East Midlands. Moreover, the group felt that the training environment did not support academic training. Trainers were aware of these feelings.

Specific issues raised by the HSTs were:

- a large number of clinics needing to be covered. New patients were sometimes seen without available consultant supervision;
- attending clinics unrelated to their chosen sub-specialty and therefore of little educational value;
- having to give sub-specialty opinions to other cardiologists;
- service pressures as a result of the CDU having an unselected acute take (trainees estimate that around two-thirds of admissions did not need to be at the CDU);
- receiving a very high volume of telephone calls when on-call during the day (up to 70 was a figure cited), while also covering the CDU and CCU from other inpatient areas and GP;
- the GP hotline working on the 'wrong direction', with trainees having to call practices and then having to wait on hold to talk to a GP.

The visit team impressed on the trainers the need to urgently address the problems within the department. An immediate priority is the provision of senior clinical input and daily supervision to all of the inpatient areas. Cardiology at Glenfield is suffering reputational damage, which will impact on future recruitment both to the department and to the training programme, which is of concern to HEE-EM.

Requirement: Instigate senior clinical input and daily supervision to all of the inpatient areas within the Cardiology unit at the Glenfield Hospital by the end of February 2016.

The department is already on the radar of the GMC due to adverse National Training Survey results for two consecutive years. Unless urgent action is taken, HEE-EM will be unable to support the continuation of postgraduate medical education and training within the department. However, the visit team was encouraged to hear that that there is commitment at departmental and Trust level from the consultants present at the visit to initiate change and that there is already a degree of insight into the issues to be addressed. A new Education Lead is in place and this individual, as well as incumbent and newly appointed consultants, needs to be fully supported to make the necessary changes.

A number of solutions are already being discussed, including using virtual clinics more widely, more specialist nurses and the use of undergraduate teaching clinics. It may be that consultants have to work differently and the department should also consider non-medical solutions. The visit team encouraged the department to meet regularly with trainees and heard that one of the consultants has volunteered to take a lead on HST well-being.

Requirement: A full action plan should be submitted to HEE-EM by no later than 23rd December 2015.

While acknowledging that some issues will take longer to resolve than others, HEE-EM is planning to revisit the department in early 2016, with external input, to assess progress and determine whether there is sufficient evidence of sustainable improvement for training to continue to be supported for all postgraduate medical trainees.

In direct contrast to the feedback from medical trainees, non-medical learners on placement within the department reported a very positive learning experience. Multi professional training opportunities are encouraged wherever possible and learners have the chance to follow the whole patient journey, thereby gaining exposure to the cardiac arrests, to the catheterisation laboratory and to theatre, as well as an understanding of procedures and of recovery. The team also heard of students spending time with cardiac exercise groups.

In general, learners regarded their placement in the department as one of the best placements they had experienced and it is not uncommon for individuals to apply to work within the department once qualified. Mentors and student links were highly valued and the students felt extremely well supported. Meanwhile mentors and student links felt to be well supported by the department.

The Mentors and student links work hard to ensure that placements reflect learner needs, which was confirmed by the learners the visit team spoke with.

Respiratory Medicine

The visit team met with a range of non-medical learners in the Respiratory Medicine department representing the disciplines of radiography, physiotherapy, occupational therapy, and nursing. Also present were medical trainees at Foundation and HST level. Following this, the team met with a range of educators from radiography and occupational therapy, as well as specialist nurses, respiratory consultants and service managers.

The physiotherapy students felt that this was the best placement they had undertaken, with lots of educational opportunities and regular teaching, including attending the physiotherapy Band 5 teaching programme. They felt well supported in meeting their curriculum competencies. Radiography students commented on how friendly and helpful the teams were within which they were placed. Within Radiography, a network of student links has been developed to strengthen the support provided to learners.

Nursing students were very much enjoying the wide range of experiences available to them within the department. They felt that being able to spend time with research nurses was particularly valuable. Placements were felt to be well organised and feedback on support from mentors was positive. However, mentors outlined the significant pressures on delivering education and training when they have no time allocated for the role and when they are having to cope with staff vacancies.

For medical trainees at Foundation, Core and HST levels, training was described as very good, with strong encouragement to attend regular teaching within the department, a good breadth of clinical exposure and opportunities to develop decision-making skills. However, staffing was raised as an issue by Foundation trainees, with rota gaps meaning that they were sometimes called to cover other wards at short notice. The trainees accepted why this needed to happen from time to time but would appreciate some advance notice (even if just

a day in advance) so that they can hand over their patients and plan their work.

Staffing challenges were also highlighted as impacting on non-medical training. As a result, non-medical education leads are looking at alternative ways of giving physiotherapy students exposure to working with the multi-disciplinary team, including opportunities to shadow nurses and health care assistants.

There was good evidence of inter-professional learning and teamwork, with nursing students welcoming the teaching on procedures Foundation doctors provide. The nursing students also felt that the junior doctors work really well as a team and find working with them on ward and board rounds very helpful. Meanwhile, Foundation doctors welcomed the support they receive from occupational therapists, nurses and physiotherapists.

In general, all of the learners would recommend their Respiratory Medicine placements / training posts and would be happy for their families to be treated in the department should they require the service.

Anaesthetics

The visit team met with a mix of novice, core and senior trainees and also a number of trainers from Anaesthetics. A presentation was given on the delivery of education and training within the department. In addition, members of the visit team spoke to non-medical learners on placement.

The trainees felt that the organisation of the rota had improved and put this down to the appointment of a rota co-ordinator. In particular, they felt the needs of less than full-time trainees were being better accommodated.

They felt that the biggest improvement over the last twelve months, which had been driven by the Training Programme Director (TPD), Dr Ralph Leighton, within the new School structure, was around the organisation and structure of training and of module allocation. Trainees were finding it easier to get modules signed off at all levels. The trainees also praised Drs Boddy, Hickman and Fell at the LRI for the support provided in facilitating their training.

Another recent improvement has been the reduction in incidents of trainees being pulled from training lists to cover service lists. While it inevitably does happen on occasions, the trainees felt that the frequency was reasonable and not excessive. Moreover, even when trainees are required to cover a service list, consultants would attempt to ensure that the list reflected the module they were undertaking so that the list would have some relevance to their training.

Trainees at core level reported being made to feel welcome at the LRI and had received a good induction.

Obstetrics and General Surgery experience was felt to be very good for core training.

Local teaching was taking place and sessions rotated between the three hospital sites. In general, the quality of teaching was felt to be good. The trainees felt that it was accessible to them when taking place at their base hospital but that it was not always well advertised when taking place at other sites, and there was a lack of coordination between rota co-ordinators across the three sites to facilitate attendance. However, HEE-EM would suggest that, to some extent, trainees do need to be proactive in finding out when teaching is taking place at the other hospital sites and to take steps to ensure that they can attend as far as is feasible. Regular ICU and ITU teaching was reported to be taking place and of a high quality and there was also a well-structured novice teaching programme. Exam teaching for primary exams received mixed feedback and it was felt that it could be more frequent. However, for final exams, the teaching was described as good and occurring regularly.

Anaesthetics trainers felt that the recruitment of Acute Care Physicians had had a positive impact on workload and their capacity to train and there have been intensive efforts made to fill rota gaps. The School requires training sites to have rotas no more intense than 1 in 7 and, with the filling of these gaps, this has been achieved within UHL. Sustainability will be dependent on the appointment of Fellows and non-training grade doctors as the number of specialty trainees is set to reduce in 2016.

There is no designated rest facility near to theatres at the LRI. With non-resident on-call shifts, there is no obligation on the Trust to provide such a facility. Nevertheless, it may be worth exploring whether its provision is feasible. This would potentially improve the attractiveness of the Trust as a place to train within a challenging recruitment environment.

Recommendation: The Trust should explore the feasibility of providing a rest room for Anaesthetics trainees on-call near to theatres at the LRI.

Novice trainees felt that they worked with too many different consultants within their first two months at the LRI, which impacted on consistency and continuity for their training. However, the trainers were aware of this and are trying to reduce the number of consultants the trainees work with. In the meantime, they have tried to allocate a designated 'buddy' consultant to each trainee as an interim solution.

The trainers were concerned that the move of services from the Leicester General Hospital to the Glenfield Hospital would put pressure on resources in Glenfield. In particular, they felt that it was essential within the department's blueprint that the trainee room, the resource room and the echo simulation room are protected. HEE-EM shares the trainers' concerns about the capacity to deliver Anaesthetics training should these resources be eroded.

Recommendation: HEE-EM would strongly encourage the Trust to consider the potential impact on training when taking decisions around resource allocation at the Glenfield Hospital to accommodate the on-going move of services from the Leicester General Hospital site.

At the last visit, there was an issue about access to the Sim. Man for simulation training. Trainees reported that while it still does not have a designated home, it is now easy to access and use whenever needed.

Overall, the visit team was impressed that not only had all issues identified twelve months previously been resolved, but that improvements beyond these recommendations were evident.

Surgical specialties – medical trainees and trainers from Plastic Surgery and ENT

The team met with trainees at core and higher level from Plastic Surgery and ENT as well as some of their trainers.

HSTs in Plastic Surgery described their training as of a good quality and a workload that is not too onerous. Core level trainees also reported having positive experiences, with consultants being very supportive in ensuring that their clinical experiences are matched to, and appropriate for, their training needs. They described nights and weekends on-call as being very busy as they cross-cover with ENT and also cover hand trauma. They have to prioritise patients during these periods and, while not considered a patient safety issue as patients are not acutely unwell, plastics and hand patients often have to wait for significant periods of time before being seen.

At HST level in ENT, feedback indicated good theatre experience, with supportive trainers. The only potential issue identified around training was that ENT lists can get cancelled at short notice if there are not enough beds. However, the trainee feedback was that they were so far progressing with their competencies. Consultants are mindful of the impact of these cancellations and are working on solutions to mitigate this. At Core level, it was felt that there are good teaching and training opportunities within UHL but that several factors are preventing these opportunities from being fully capitalised on. Rota gaps have reduced theatre opportunities and there is pressure from a high volume of referrals from urgent care and primary care. Nonetheless, good consultant support was described. The department is seeking to recruit a Research Fellow and a Simulation Fellow, which will help with rota gaps and strengthen the support available to junior trainees.

Trainees also mentioned issues with HEE-EM's curriculum study leave process, which will be fed back internally to the relevant teams.

Dental Training

The visit team met with Dental Core Trainees and then their educational and clinical supervisors. The trainees felt that they were gaining a broad experience: within a busy, high volume unit. They reported that they attended a corporate induction, and received information about the unit. Any gaps in information were filled during their ward orientation. Trainees claimed that they were not routinely using their e-portfolio as the new version is not particularly easy to use. The trainees reflected that they would welcome some training on how to use it as part of their induction would be welcome. Local teaching sessions also take place on Thursdays and are protected.

The trainees felt generally well supervised in their day-to-day clinical work. They are beginning to take

on increasing amounts of minor oral surgery. In addition, they are also able to attend cancer clinics, theatres as well as undertaking ward-based work.

Overall the trainees were happy with the range of work they were undertaking and the educational opportunities this afforded them.

The educational and clinical supervisors reported that they had a nominal allowance for undertaking there educational roles and were unaware of the Trust's position with regard to recognition of educational and clinical supervision. The trainers reflected that there had been increased communication over the past year or so from the Trust education team.

The trainers reported that they would welcome training in the use of the new e-portfolio and this will be fed back to the School of Dentistry.

The trainers told the team that following the feedback from the visit last year, when trainees reported that they felt they were supernumerary for too long, they had amended the shadowing period for core trainees to two weeks. This enables them to become involved in clinical work more quickly.

Showcase Session

The Trust organised a showcase session for the visit. There were a variety of stands / posters displaying a range of education and training related initiatives and good practice, both in relation to medical and non-medical education (and some multi-professional).

Following the visit, HEE-EM is in the process of working with the Trust to document the initiatives, with a view to publishing areas of good practice identified during its 2015 Quality Management visits in the New Year.

5. Recommendations & Requirements

Requirements

1. HEE-EM requires confirmation as to whether medical trainees are required to undertake shifts / weeks where they are only discharging patients and, if this arrangement is still in place, how frequently it occurs and how the impact on education and training is taken into account;
2. Handover and the transfer of patients needs to be more robust across the acute medical care pathway at the LRI for both patient safety and educational reasons;
3. Instigate senior clinical input and daily supervision to all of the inpatient areas within the Cardiology unit at the Glenfield Hospital by the end of February 2016;
4. A full action plan should be submitted to HEE-EM by no later than 23rd December 2015.

Recommendations

1. Explore the appropriateness and practicality of trainee Advanced Practitioners attending CMT teaching rather than FY1 teaching;
2. Look at whether Advanced Practitioners can be given access to SystmOne;
3. Reflect on the suggested improvements made by the mentors and supervisors to see if any changes can / need to be made;
4. The Trust should explore the feasibility of providing a rest room for Anaesthetics trainees on-call near to theatres at the LRI;
5. HEE-EM would strongly encourage the Trust to consider the potential impact on training when taking decisions around resource allocation at the Glenfield Hospital to accommodate the on-going move of services from the Leicester General Hospital site.

6. Action Plan

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