Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 October 2017

Title and Author of Paper:

NTW Postgraduate Medical Education annual self-assessment report to HEE(NE)

Bruce Owen, Lisa Insole, Frauke Boddy, Emma Paisley

Executive Lead: Rajesh Nadkarni

Paper for Debate, Decision or Information: Information and discussion

Key Points to Note:
This is the trusts annual self-assessment of medical training, both undergraduate and postgraduate. This document in used by HEE(NE) and Newcastle University as part of their quality assurance processes and informs their annual trust visit.
The report is structured used GMC standards and looks at how the trust performs medical education.
In completing this we triangulate a range of quality metrics to provide an overall picture of our training, strengths and challenges

Risks Highlighted to Board :
We have within the report identified key risks to training, the main one of these is recruitment of medical staff, both trainees and trainers

Does this affect any Board Assurance Framework/Corporate Risks?
Please state Yes or No
If Yes please outline

Equal Opportunities, Legal and Other Implications: N/A

Outcome Required: N/A

Link to Policies and Strategies:
Links to range of clinical and workforce policies and strategies including medical workforce strategy and supervision policies

2017 Self-Assessment Report (SAR)

Postgraduate Medical & Dental Education

(Reporting Period: 1 August 2016 to 31 July 2017)

Trust's name:	**Northumberland, Tyne and Wear NHS Foundation Trust**
Value of contract / funding with HEE NE	**£3,745,658 PGME (+ £1,750,000 SIFT)**
Trust Chief Executive's name:	**John Lawlor**
Director of Medical Education's name (or equivalent, please state job title):	**Bruce Owen**
Report compiled by (responsible for completion of):	**Bruce Owen, Lisa Insole, Prathibha Rao, Frauke Boddy, Emma Paisley**
Report signed off by:	
Date signed off:	
Board Approval: 1. **Approved by / on behalf of the Trust Board: (date / details)** 2. **Date seen at or scheduled for Board meeting**	

The SAR is aligned to the GMC Standards for medical education; http://www.gmc-uk.org/education/index.asp the GMC themes, and the HEE standards which includes a sixth theme, developing a Sustainable Workforce: https://hee.nhs.uk/our-work/planning-commissioning/commissioning-quality

The SAR should be read alongside;

1. *The Standards Dashboard (appendix to the SAR)*
2. *The Quality Improvement Plan (The QIP)*
3. *The collated departmental / unit reporting template*

1. Organisation overview linked to the GMC/HEE Standards

(Refer to GMC Standards for medical education / HEE Standards)

*This section should be used to document a **high level summary** of the successes your organisation is most proud of achieving during the reporting period and highlight any challenges or important issues you would like HEE NE to be aware of now. We recommend organisations complete this section following collation and completion of the departmental (unit) reports.*

Successes the organisation is most proud of achieving during the reporting period:

GMC standard theme 1 – Learning Environment and Culture
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. **S1.2** The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum
1. We are pleased that feedback from both the GMC trainee and trainer surveys have continued to be positive. We have retained our position as the second highest placed trust in the North East in terms of the quality of postgraduate medical education in the trainee survey. We have achieved this despite very significant pressures relating to recruitment not only at a junior doctor level but also at consultant level. Overall GMC survey scores are better/maintained in picture of nationally falling scores. 2. We have proactively managed issues relating to recruitment and provide details of the strategy below. We aim to backfill all vacant posts using a variety of methods. Our success in this area is reflected in the workload satisfaction score in the GMC Survey 2017: mean satisfaction for workload was 61.38% (5 year average was 57.36%). The national mean is 47.20%. 3. We have been focussed on maximising trainee involvement in innovation and leadership: Trainees are represented on committees both within and outwith the trust including representation on the RCPsych Psychiatric Training Committee. Our trainees successfully delivered the RCPsych's 'Supported and Valued' focus group in Newcastle. As a result of this, they have created the Trainees Leading and Implementing Change Group, which includes leading on quality improvement projects. Trainees from this group have been invited to speak to the trust board and the chief executive will be attending an upcoming meeting. 4. Clinical supervision for junior trainees out of hours has improved linked to a change in some second on-call rotas from an on-call to a shift system. This change has been evaluated demonstrating improved face to face clinical supervision, improved feedback and an increase in junior trainees having WPBAs completed out of hours.
GMC standard theme 2 – Educational Governance and Leadership
S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met. **S2.2** The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

1. Over the reporting year we have started to benefit from the increased investment in educational governance and quality improvement. Our new quality and safety lead has worked with college tutors to strengthen the processes we have in place around reviewing individual posts through regular meetings with trainees and review of end of post feedback. This has improved our ability to respond to trainee concerns and feedback to trainers about quality.

2. We have consciously developed systems to ensure medical education and training is given higher profile across the trust. This has been done both at the local level with regular slots for the DME/AMD PG education to attend local consultant meeting and feedback and discuss education and at a more central level through attendance at key trust meetings and regular board presentations.

3. There have been two important changes in the last year that have improved systems to support training and clinical issues raised by trainees to be addressed. The first of these is the Guardian Forum, whilst we had some reservations about the new junior doctor contract this component of it has proved to be a useful mechanism to meet with trainees and discuss relevant issues. The supported and valued initiative mentioned above is the second system that has been addressed to all trainee issues to be addressed.

4. We have updated policies on clinical supervision for trainee medical staff and managing performance concerns with trainee medical staff. Both these policies are integrated with wider clinical and medical policies and importantly consider patient safety and trainee training need alongside each other again ensuring an integrated approach to governance.

5. GMC survey results in the parameters relating to educational governance, reporting systems and supervision all remain above the national average. In the measures of clinical supervision, in and out of hours and reporting systems where there is data going back some years our score this year was also higher than our five year average score showing an upwards trend.

GMC standard theme 3 – Supporting Learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Our in-house training complements training delivered by our partners in the foundation, psychiatry and GP schools. We have been delivering a trainee development programme for many years. New innovations this year include:

Higher trainee initiatives:
Based on feedback from the GMC, a new training programme has been developed for higher trainees focussed on the development of leadership and management skills.

International Medical Graduates:
We have employed a consultant to develop and deliver a package of support for international

medical graduates including workshops and pastoral support. This programme is now being delivered with encouraging feedback.

Trainee led developments:
These initiatives have input by senior clinicians from the med ed team.

1. CASC preparation courses and mock examinations
2. Bespoke GP training programme focussing on what a GP needs to know about psychiatry

GMC standard theme 4 – Supporting Educators

S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.
S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

1. Our Faculty Development Programme has continued to develop; over the reporting year we offered ten training events for trainers specifically focussed on PG education and 3 events focused on UG education. In total over 100 trainers attended these sessions which were consistently rated highly.

2. Audit of our appraisal process over the last year has shown that in a random sample of 20 trainers, 100% had their training role identified in their appraisal, and 100% presented evidence in their appraisal specifically relating to this training role (all had attended education/training focussed CPD, 94% included feedback on their training role and 71% had reflected on this).

3. We were pleased with the GMC Trainer Survey results from 2017 showing we are a positive outlier for the trainer development score, and scored above the national average for support for trainers (NTW score 76.69, 5.28 above national average) and overall trainer satisfaction (NTW score 79.39 compared with national mean of 71.87. We also scored well in the score looking at time for training (NTW 65.3, national average 56.28) and resources or trainers (NTW 75.82, national average 70.59) which is in part a reflection of our trust guidance around time for training in job plans where trainers have 0.5SPA allocated for the supervising role.

GMC standard theme 5 – Developing and implementing curricula and assessments

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates. (N/A for Postgraduate)
S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

1. Over the previous 2 years prior to the current reporting period we were concerned about one area of curricula coverage namely emergency psychiatry for core specialty trainees. We are confident the measures we have put in place over the last 2 years have addressed this. In the School of Psychiatry Survey, January 2017, 83% (covering 4 Trusts 51% being from NTW) felt that their exposure to emergency work was sufficient for their training needs and curricular requirements. In our own recent survey trainees were seeing a mean of 6 emergency psychiatry cases a month across the Trust.

2. Since the advent of exception reporting through the new junior doctor contract, there has

only been one exception report related to a missed educational opportunity and when reviewed this event was not a core part of the required training programme.
HEE standard 6 – Developing a sustainable workforce
6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes. **6.2.** There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities. **6.3.** The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service. **6.4.** Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner. HEE NE guidance: Examples of workforce strategies being used throughout the Trust or within individual departments/training programmes where planned training delivery (e.g. as part of new JD contract 'job plan') for individual or groups of trainees is protected from service pressures (e.g. acute or predictable rota gaps) through the use of non-training workforce to deliver the service (e.g. Consultants/Trust Doctors providing acute cover, non-medical staff providing service).
Workforce pressures, particularly relating to the medical workforce are an increasing priority for us as a trust. We have dedicated significant time and resource to addressing this. It is of note that this issue is being looked at from a board and executive level as well as throughout the trust. We as a trust have a medical workforce strategy which has within it a number of initiatives aimed at developing a sustainable workforce. Initiatives include: 1. Overseas recruitment initiative, this has focussed on consultant and SAS recruitment from India. We are currently exploring linking formally with the National Institute of Neurosciences and Mental Health in Bangalore to enhance research and training opportunities. 2. International Medical Graduate support programme, as described under Standard 3. 3. Higher trainee programme focussed on making the transition to being a consultant and resilience. 4. SAS Fellowship programme, this is a new initiative aimed at supporting SAS doctors to join the specialist register through the CESR process. The programme has been developed over the last year and will be recruited to in the next six months.

2. Challenges or important issues that HEE NE should be aware of:

(Please reference to QIP action if applicable)

Remember; a challenge doesn't always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.
Please also include any inspections or findings such as ratings from the CQC.

GMC standard theme 1 – Learning Environment and Culture
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. **S1.2** The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum
1. Recruitment remains a very significant challenge both at a junior and consultant level. We have taken a robust stand to protect training and the trust has allowed us to do this. We have moved trainees and reconfigured posts if consultant retention issues were adversely affecting a training post. Examples of both are listed below: • Reconfigured post: we changed a core post from a split adult community/peri-natal post to a whole time peri-natal post with community and inpatient aspects. The reconfigured post has received 10/10 in feedback. • Example of trainees moved: the service were unable to recruit a consultant to an inpatient old age ward. Trainees were moved from this ward to another ward and we worked with the service to ensure patient safety on the ward where we no longer allocated trainees. This included recruiting a locum once adequate medical supervision was identified. We also asked the service to provide a weekly diary of medical cover to the ward to be shared with local trainees on the on-call rota so that they would always be able to access appropriate supervision. We have met with the trainees and no issues related to inadequate supervision were identified. 2. The financial position remains a significant challenge to the trust and is an ongoing challenge. As a trust our recent CQC outstanding rating demonstrates not only delivery of high quality care but also sound financial management. We have as a trust ensured monies dedicated for training remain ring-fenced for this and sit within the Medical Education budget, this remains an important element of ensuring training is not adversely impacted on by financial pressures. The changing junior doctor contract has however resulted in some additional financial burdens for the trust relating to training budgets.
GMC standard theme 2 – Educational Governance and Leadership
S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met. **S2.2** The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

GMC standard theme 3 – Supporting Learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

1. Trainees have highlighted through a number of sources that time spent entering data on the electronic record negatively impacts training. In the School of Psychiatry survey 2017 (across 4 trusts), only 15% disagreed with the statement: 'the amount of time I spend completing electronic records negatively impacts on my face to face time with patients'. We have been working with the Trust to streamline the admission discharge documentation, to reduce repetition and help to get timely accurate information to GPs as soon as possible. This remains a work in progress. The new document is being road-tested on our electronic system.

GMC standard theme 4 – Supporting Educators

S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.
S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

1. We have noted within the section on achievements we are proud off, positive results from an audit of how trainers are appraised in their training role. Whilst we were pleased to see that all trainers both identified their training role within the appraisal document and provided evidence relating to this role it is of concern that only 82% of appraisers commented on the trainers training role in their summary documentation. We see this as a training issue for appraisers have started training to support appraisers in this as well as looking at building additional prompts into appraiser guides.
2. Although our GMC trainers survey score in the parameter looking at time provided for training is almost 10 points above the national mean at 65.3 we are nevertheless concerned. This figure suggests that clinicians are feeling under significant clinical pressure which has the potential to impact on training. We are aware of isolated incidents where this has occurred and we are keen, through our enhanced quality management process, to identify areas where training is being adversely impacted by recruitment and service pressures. This should allow us to support the trainer and protect their time as well as protecting trainee experience.

GMC standard theme 5 – Developing and implementing curricula and assessments

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates. (N/A for Postgraduate)
S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

1. We have recently identified a potential threat to the delivery of the CBT short case in the trust through problems accessing patients through IAPT. In the interim solutions have been developed to ensure trainees are not disadvantaged. A business case is in development to bring this training in-house.

HEE standard 6 – Developing a sustainable workforce
6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes. **6.2.** There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities. **6.3.** The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service. **6.4.** Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner. HEE NE guidance: Identify issues throughout the Trust or within individual departments/training programmes where planned training delivery (e.g. as part of new JD contract 'job plan') for individual or groups of trainees is not being protected from service pressures (e.g. acute or predictable rota gaps) and outline the workforce strategies being developed to address these issues (e.g. Consultants/Trust Doctors providing acute cover, non-medical staff providing service).
1. The national position for recruitment into psychiatry is a significant challenge to us. Centre for Workforce Intelligence figures predicts and increasing problem over the next twenty years nationally with a shortfall in the order of 7%. Local core recruitment into CT1 was low for 2017. This is an area we have prioritised and through a range of initiatives have been able to minimise this problem locally. Initiatives in place include a range of approaches some aimed at relieving immediate pressures other looking more at longer term solutions.

3. Faculty of Postgraduate Medical and Dental Education

3.1 Faculty roles, organisation and accountability

If there have been any changes to your organisations educational governance structures since the previous SAR please detail this here, otherwise please state 'no changes'.
If there are any vacant roles, or risks to medical education please describe these here, including any plans to mitigate that risk.

We have expanded the number of teaching fellow posts from five to seven over the last year. Following the retirement of Prof Lunn we have appointed a new AMD for UG education Dr Frauke Boddy. We have created and appointed to three new lead roles, each supported by one session of time: Simulation training lead – Dr Sarah Brown IMG training lead – Dr Ursula Reckermann SSC lead – Dr Clare McLeod We have also appointed a Guardian of Safe Working – Dr Andrea Tocca.

3.2 Faculty development (non-consultant colleagues only)

Please provide answers to the following questions.
You may wish to appendix funding details, as required.

Questions	Trust's answer
Number of SASG doctors within the trust	**31**
Total SASG funding received	**£18,000**
Is the SASG funding ring-fenced to support SASG doctors only? (Y/N)	**Yes**
Please describe the process by which the development needs of SASG doctors within your organisation were individually and collectively identified. Using funding allocated for SASG development; How were priorities decided?	**We have a SAS business meeting as part of each forum during which the groups needs are discussed and feedback on specific training needs are used to inform an ongoing programme of CPD** **The final decisions sit with the SAS tutor**
SASG nominated lead within the trust	**Dr Victoria Thomas (for the reporting period)**
Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)	

	Spending	Detail
1. Individual doctor's development (i.e. details of spending used to support the development of		**All SAS doctors have access to study leave budget of £1000 per**

individual doctors including an anonymised list of amounts and what it was used for)		**annum in addition to the SAS forum**
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered)		£1873 – costs for delivery of SAS forum events: **09/11/16** Positive Behaviour Support – Greta Brunskill & Nicola Dodds Physical Health – Dr Melanie Grundy Theory & Reality of Risk Assessment (If U Care Share Foundation) – Steve Taylor & Shirley Smith **23/03/17** High Dose Antipsychotic Therapy/Polypharmacy – Dr Zakaria Ali Toxicology – Dr Nigel Brown (Newcastle Uni) Inc. consent – are you fully informed & good practice in prescribing with Rachel Woodall (GMC) **04/07/17** NEAP/AC/Section 12 Approval – Dr Gill Bell Evidence Based Medicine – Matthew Linsley (New Uni) Medical Director Update – Dr Rajesh Nadkarni
3. Payment for SAS tutors/leads sessions		1 session of time
4. Administrative costs to support SAS tutors		0.2 WTE of band 3 admin time
5. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)		

4. Good Practice items

Also supporting the standards, please list any good practice items that you would like to highlight as an exception over and above the supporting departmental / unit information. These may include trust wide initiatives as well as departmental / unit examples. When considering items to list here, please consider the GMC definition of good practice;
You don't need to duplicate items from the successes section of the SAR.

"…areas of strength, good ideas and innovation in medical education and training. Good practice should include exceptional examples which have potential for wider dissemination and development, or a new approach to dealing with a problem from which other partners might learn. The sharing of good practice has a vital role in driving improvement, particularly in challenging circumstances".

GMC standard theme 1 – Learning Environment and Culture

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
Re-design of second on-call out of hours rota Contact: Dr Bruce Owen	Improves supervision of junior doctors out of hours and protects the pay of these trainees.
S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
Supported and Valued Forum and Trainees Leading and Implementing Change Group, which includes leading on quality improvement projects. Contact: Dr Eleanor Romaine	This initiative involves trainees in developing skills in leadership and quality improvement. The trust values this initiative such that they have been asked to present to the board.

GMC standard theme 2 – Educational Governance and Leadership	
S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
1. Funding of a new post to specifically focus of quality of training, evaluating and sharing quality metrics and supporting sharing of good practice Emma Paisley and Dr Bruce Owen	Through having a dedicated post we have been able to not only prioritise the issue of quality but it has been possible to examine the metrics at a more granular level allowing us to respond to areas of good and less good practice. The dynamic nature of this role has allowed changes in quality in training to be more quickly identified.
2. Trust approach to Guardian Forum Drs Andrea Tocca, Bruce Owen and Lisa Insole, John Moore and Amanda Venner	We have found the Guardian Forum to be a highly valuable forum to identify and respond to training issues. We have actively encouraged the use of exception reporting, extending this to those on old as well as the new contract. This approach we feel has allowed what was at risk of being a forum that was not valued to one that is highly valued
S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.	

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice
S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**

GMC standard theme 3 – Supporting Learners	
S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
CASC preparation courses Contact: Dr Eleanor Romaine.	Trainees have led on the development of this programme with support from the medical education team. Consultants are involved in the assessments.
GP training course Contact: Dr Emily Dolton	A bespoke training package was developed to meet the curricular needs of GP trainees to focus specifically on what a GP needs to know about mental health.
Higher trainee training Contact: Dr Bruce Owen and Dr Rachel Gore	Leadership and Management 3 days course. The focus of this programme has been preparing trainees for being consultants and equipping them with the skills to manage both the transition to and working as a consultant. This has had high level support from the executive team.
International Medical Graduate Initiative Contact: Dr Ushi Reckermann	Training and support package for international medical graduate trainees, the development of this has been an important initiative in supporting new IMG both in the short and longer term.

GMC standard theme 4 – Supporting Educators

S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
Induction for new trainers Contact: Dr Lisa Insole and Karen Peverell	An induction pack has been developed for new trainers and an induction meeting is held. New consultants coming to the trust are identified through medical staffing.
S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**

GMC standard theme 5 – Developing and implementing curricula and assessments	
S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates. (N/A for Postgraduate) **S5.2** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
Emergency Psychiatry Innovations Contact: Dr Lisa Insole	We have addressed concerns about provision of emergency psychiatry training by developing a series of daytime rotas in either liaison or crisis teams to deliver training in this area. This occurs in conjunction with simulation training in emergency psychiatry and induction workshops on common emergencies.

HEE standard 6 – Developing a sustainable workforce
6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes. **6.2.** There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities. **6.3.** The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service. **6.4.** Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner. HEE NE guidance: Please provide specific examples of workforce strategies/innovations/interventions which have been

effectively implemented (and which you consider good practice as defined above) within your Trust to protect the delivery of planned training from service pressures.	
Description of good practice (and a named contact for further information)	**Description of why this is considered to be good practice**
IMG initiative and Higher trainee training could both be described within standard 6 but are detailed under standard 3	

5. Specialties at highest risk of not meeting a standard (narrative to support the Standards Dashboard)

Appendix 1 to the SAR

From the Standards Dashboard, Please list any specialties which are not fully meeting a standard (those rated as "not met" are items which have a high risk of standards not being met. Please list the specialty and the standard along with any further detail or background that will help describe the current situation.

Specialties listed here should also be added to the QIP.

Within our dashboard we have rated a number of areas as partially met:

1. At CAV we have rated supporting learners as only partially met as we are aware the local PG teaching programme has suffered some recent drop in feedback. Looking at this it appears that a significant factor in this is ensuring trainees have their teaching time protected and we are looking at how this can be improved.

2. In MWH we have rated supporting learners as only partially met, we are aware that the scores for educational and clinical supervision were low at this site. This appears to reflect problems with supervisor recruitment and we are meeting locally with trainers and the service to address this.

3. In SGP we have rated supporting learners and curriculum coverage as partially met as we are aware that there have been ongoing problems with supervisor recruitment and additionally this appears to be a particular area where the administrative burden of the IT system and demands around physical health care are noted. We have been and continue to work with local services to look at supervision arrangements and have made significant progress in this including making changes in some training posts. We are also within the trust clinical teams exploring how we can find the correct balance between psychiatric training needs and physical health care needs, which whilst overlapping need to be appropriately balanced.

4. In GP training we have rated curriculum coverage as partially met as although all posts have at least three sessions of community time we would like to increase this further to better meet GP training needs.

5. In HWP we have rated theme one as only partially met due to data linking to handover of clinical information. We are currently working with trainees to explore this further and identify solutions.

6. Additional Information/Questions

6.1 Academic Trainees

Please describe how the LEP supports academic trainees, clearly highlighting any challenges or good practice items

NTW is the third most research active mental health trust in England and we are able to provide a range of good academic supervision across all psychiatric specialities.

We actively promote the ACF scheme and encourage both foundation and core trainees to consider this.

We have flexible training posts that can accommodate trainees in ACF posts and have taken a flexible approach to how research time is planned, with some trainees doing this in blocks and others regular slots depending on the needs of the research project.

We currently support 4 ACFs.

6.2 Undergraduate

Please provide narrative and evidence of how the following are being met. Please also highlight any issues or concerns, including any areas which are not being met. *(Additional prompts have been added under each heading)*

GMC standard theme 1 – Learning Environment and Culture

- Students were provided with sufficient opportunities to meet learning outcomes
- Students received sufficient feedback to track and direct their learning
- Students were satisfied with the overall organisation of the placement
- Students were satisfied with the overall quality of the Stage
- Clinical teachers were punctual and reliable in their attendance. (Due regard will be given to mitigating circumstances of urgent clinical need)
- The overall quality of the teaching was of a consistently high standard

Overview:

In 2016/17 the medical education department, clinical areas and the wider trust have supported:

Essential Senior Rotation (final year, stage 5)	Sept –Dec 2016 4 cohorts 3 week rotation	209 students (total): Northumberland/North Tyneside:48 Tyne: 105 Wear: 56
Essential Junior Rotation (third year, stage 3)	Jan – Jul 2017	206 Northumberland/North Tyneside: 60 Tyne: 91 Wear: 55
SSC students (stage 4 individual placements)	2017	43

The medical education department and the wider trust continue to regard undergraduate medical education as a high priority and have continued their work to raise the profile and quality of undergraduate medical education over the period 2016/17.

The current recruitment crisis in psychiatry is an on-going and increasing challenge to the provision of medical student attachments. The medical education department are addressing these issues in a number of ways.

- Expansion of teaching fellow posts:
  - 2014/15 - 1 teaching fellow
  - 2015/16 - 2 teaching fellows
  - 2016/17 - 5 teaching fellows
  - 2017/18 - 7 teaching fellows

- New base unit leads for the Northumbria and Tyne base units have come into post, increased time for Northumbria Base Unit lead to 2 PAs/ week.

- Increase in and restructuring of administrative support for the base units – there has been increase in administrative time – there is now a dedicated administrator aligning to each base unit with a total of 2.5 WTE across the undergraduate service (1.5 band 4, 1 band 3). By linking Tyne and Northumbria arrangements are now more robust.

- Appointment of a clinical SSC lead to improve the provision and quality of SSCs, supported by 1 PA.

- Development of resources and facilities for medical students, which included the provision of a psychiatry textbook for each student for the period of their rotation and the provision of a student room at St George's Park, including PC/ IT access.

- The teaching fellows have started to broaden their level of input to help support the students' clinical in-patient placements

- Development of teaching methods and approaches, introducing more interactive teaching sessions using technology, also further developing simulation teaching to enhance the students' clinical reasoning and readiness for clinical practice

Review of university feedback:

The Medical School have altered the questions students are asked for the end of rotation feedback and aligned them to the new GMC standards. In some areas direct comparison of feedback results is therefore more difficult this year.

Stage 5 (September - December 2016)

1. Students were provided with sufficient opportunities to meet learning outcomes.

Two particular questions in the 2016/17 university feedback relate closely to this:

1. In order to meet my learning outcomes, I had access to clinical areas
2. The scheduled teaching sessions help me achieve my learning outcomes
3. Overall, the quality of teaching was of high standard

2016/17

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
a.	90%	90%	74.3%	97.6%
b.	85%	86.6%	82%	83.3%
c.	85%	80%	76.9%	96.2%

2015/16 data from the following questions for comparison:

(a) Students were provided with sufficient opportunities to meeting learning outcomes

(c) The overall quality of teaching was of a consistently high standard

2015/16

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
(a)	75.5%	73.1%	86.8%	95.1%
(c)	84 %	80.8%	84.2%	90.2%

2. Students received sufficient feedback to track and direct their learning.

Two questions in the student feedback relate directly to delivery of feedback:

4. I received constructive and meaningful feedback on performance, development and progress during my placement and at my in-course assessment
5. My assessment facilitated the development of self-assessment, reflection and a desire to learn, develop skills and seek out further assessment and feedback

2016/17

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
c.	93.3%	83.3%	84.6%	90.48%
d.	91.6%	83.3%	82.05%	90.48%

2015/16 data from the following questions:

(c) Students received sufficient feedback to track and direct their learning

2015/16

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
(c)	89.2%	88.5%	93.4%	91.5%

3. Students were satisfied with the overall organisation of the placement.

(d) Students were satisfied with the overall organisation of the placement.
(e) Clinical teachers were punctual and reliable in their attendance (due regard will be given to mitigating circumstances of urgent clinical need)*

2016/17 (2015/16)

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
(d)	78.3% (64.7%)	60% (76.9%)	58.9% (78.9%)	97.6% (87.8%)
(e)*	96.7% (90.2%)	90% (76.9%)	92.3% (72.7%)	95.2% (92.7%)

*2016/17 based on the question formal/scheduled teaching took place as planned

The stage 5 feedback from 2016 highlighted a number of issues.

We are pleased with the continued positive feedback for the Wear/ Sunderland based rotation. Changes brought in place in 2015 continue to result in a positive student experience.

The feedback for the Tyne base unit has continued to improve, mostly for the SNH site. The feedback for students based in Gateshead was more varied, but there was a significant deterioration in the satisfaction scores for the Northumbria base unit. It is of note, when reviewing the Northumbria feedback on a cohort by cohort basis that the feedback was very variable between cohorts. Cohorts 1 and particularly 3 had very poor feedback scores compared with cohorts 2 and 4.

Because the administration and formal teaching are the same for both the Tyne and the Northumbria base units, it is considered that the reason for the difference in satisfaction scores for "organisation" is the clinical teaching which is more vulnerable to changes in staffing levels.

This is supported by the fact that the dip in feedback scores coincided with a loss of clinical staff in key clinical areas of the service, which lead to increased pressure on the medical teams. In response to this the teaching fellow for Northumbria was brought into a key clinical area to support the delivery of bedside teaching and the improving feedback for cohort 4 was seen as evidence that this approach was starting to have a positive effect.

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Stage 3 (January - July 2017)

1. Students were provided with sufficient opportunities to meet learning outcomes.

The following questions in the feedback relate closely to this:

a. In order to meet my learning outcomes, I had access to clinical areas
b. The scheduled teaching sessions help me achieve my learning outcomes
c. Overall, the quality of the teaching was of high standard

2016/17

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
a.	64.07%	90.00%	87.27%	100.00%
b.	87.03%	87.22%	92.73%	96.29%
c.	88.70%	90.55%	94.63%	98.14%

2015/16 data from the following questions:

1. My placement provided me with the learning opportunities to meet my learning objectives
2. My clinical experience was relevant to my learning objectives
3. Overall, the quality of the teaching was of high standard

2015/16

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
(a)	87.8%	82.8%	95.9%	82.2%
(b)	87.8%	93.1%	96.9%	91.9%
(c)	(80.5%)	(82.8%)	(89.8%)	(77.8%)

2. Students received sufficient feedback to track and direct their learning.

Two questions in the student feedback relate directly to delivery of feedback:

d. I received constructive and meaningful feedback on performance, development and progress during my placement and at my in-course assessment
e. My assessment facilitated the development of self-assessment, reflection and a desire to learn, develop skills and seek out further assessment and feedback

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
d.	85.85%	93.88%	96.36%	94.44%
e.	87.03%	100.00%	92.73%	100.00%

2015/2016 (scores for 5 questions on feedback)

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
Feedback	89.0%	85.6%	94.6%	67.0%

3. Students were satisfied with the overall organisation of the placement.

9 questions related to organisation and induction in 2016/17 their mean score is compared with mean scores for 5 questions on organisation and induction (2015/16).

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
Organisation	86.60% (91.1%)	91.29% (80.7%)	91.91% (97.5%)	91.54% (81.8%)

We are very pleased that the feedback for the stage 3 rotation is very encouraging and much more positive than that from the preceding stage 5 rotation. In contrast to the senior rotation Northumbria students showed high rates of satisfaction.

It is of note that the 2016/17 questions include direct questions addressing the learning environment and the satisfaction ratings, these ratings were very low for the Tyne and in particular the Northumbria rotations. They have improved in the subsequent EJR, but are still lagging behind the rest of the feedback – Areas the questions are addressing are in part a function of teacher engagement and the provision of nominated supervising clinicians during the students' placements.

New initiatives introduced:

- A new **case based learning session** for ESR in Northumbria and Tyne was designed by teaching fellows to support interactive and self-directed learning around developing management plans concerning the core conditions. Feedback for the session was positive.

- Teaching fellows' clinical time was increasingly aligned with clinical areas of need (in terms of student support and supervision) - in particular the St George's Park in-patient unit. Teaching fellows were timetabled to provide bedside teaching in those areas.

- North of Tyne students were offered the opportunity to spend time with the Street Triage team. This received very positive feedback from students, as demonstrated in example comments below:

- The Wear base unit produced a student workbook – this identified learning opportunities for students in a number of clinical areas and aimed at increasing the students' ability seek out such opportunities in the Mental Health service setting and become more self-directed, independent learners In addition it provides the students with some directed learning activities which can help the student and clinical teachers, providing them with added educational opportunities.

- This has received positive comments in local feedback:

    - "options to make better use of "downtime" by guiding their learning

    - questions with which to reflect on what students have done that day, and whether they have achieved the learning outcomes of the sessions

    - a useful revision tool."

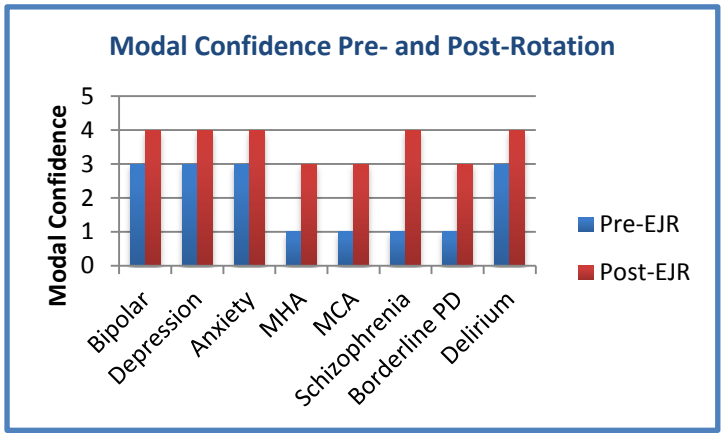
Projects 2016/17:

A number of trainees and students conducted evaluative projects exploring the impact of psychiatric placements in the Tyne/ Northumbria base units on knowledge and attitudes:

"The impact of the EJR on subjective confidence and knowledge of psychiatric terminology" (Dr Monica Parker, FY1 et al)

A list of **eight psychiatric terms** was created based on core MBBS curriculum content. A

questionnaire was created with space to write a **free-text definition** along with a **five-point confidence scale** for students to rate how confident they were in their understanding of the term. The questionnaire was distributed on day one of the four-week EJR, and a repeat questionnaire was distributed during the last week of the rotation. The **modal confidence levels** for each term were compared and the qualitative definitions analysed.



We concluded that knowledge and confidence in defining common psychiatric terminology is increased by the EJR. However, our work highlighted that third year medical students appear to be coming into the EJR with very limited knowledge of common psychiatric conditions, highlighted by low confidence scores and incorrect definitions at the start. There were also many negative and stigmatising terms and definitions at baseline, illustrating that even amongst a cohort of students with two years prior medical training, common psychiatric conditions continue to be stigmatised, notably schizophrenia, bipolar disorder and borderline personality disorder. The impact of this low baseline of knowledge and high level of stigma on learning and engagement with the EJR could be further explored in future."

The evaluation survey has been presented in poster format by Dr Monica Parker at the RCPsych International Congress 2017 in Edinburgh, at the RCPsych Medical Education Conference in Belfast, and at our own NTW Medical Education Conference 2017. Monica's poster for the RCPsych IC also achieved The RCPsych Student prize of the year (Education and Training) Award.

"The impact of the EJR on undergraduate attitudes to psychiatry" (Elle Clarke, SSC student)

Summary

We were interested in evaluating the impact of our Stage 3 Mental Health EJR on student attitudes to psychiatry and produced an adapted version of the Attitudes To Psychiatry (ATP) questionnaire which we distributed at the EJR induction session and at a session in the last week of the EJR. The findings of these questionnaires were analysed to note a percentage change in the numbers of students agreeing (strongly agree/agree) or disagreeing (strongly disagree/disagree) with the attitudes in question.

Elle Clarke, Stage 4 SSC student, designed an innovative session as part of her SSC project and delivered this to subsequent cohorts 4 and 5. The learning objectives of her interactive session were: to better understand the different subspecialties of psychiatry; to better understand how psychiatry and psychiatrists work in tandem with other specialties;

and to demonstrate the exciting and rewarding nature of psychiatry

In conclusion, this quality improvement project appeared to show an improvement in undergraduate attitudes to psychiatry following intervention.

This evaluation survey was presented in poster format by Elle Clarke at the RCPsych International Congress 2017 in Edinburgh, at the RCPsych Medical Education Conference in Belfast, at the TASME Spring Conference 2017 in Keele, at our ADQM visit (April 2017) and at our own NTW Medical Education Conference 2017. Elle's poster abstract for the RCPsych IC also achieved the Psychiatric Trainee's Committee Student Award and bursary.

"The impact of the SSC period on undergraduate attitudes to psychiatry" (Dr K Hay, ST4 Psychiatry)

Aims
To explore the attitudes to psychiatry of fourth year medical students at the start of their Student Selected Components (SSCs), and to compare these with third year medical students at the end of their mental health clinical placements.

Results
In regards to the impact of the SSC period, positive effects can be seen in the students' attitudes concerning the use of medical training within psychiatry and psychiatry being an exciting speciality. More concerning though are the results suggesting a reduction in the number of students who agreed they would consider being a psychiatrist (-6%) and the increase in students who disagreed with the same statement (+9%); contrary to what we hoped an SSC in psychiatry might achieve. There was also a negative impact in regards to the number of students agreeing that psychiatrists get less satisfaction from their work than other specialists (+6%). None of the evaluation results are statistically significant ($p>0.05$).

Discussion
These attitudes may go some way to explain why there might be a recruitment crisis in psychiatry and raise a concern that experiences outside of psychiatry between third and fourth year placements may be damaging attitudes to psychiatry among undergraduates. Bearing in mind that the SSC students have opted to do an additional rotation in psychiatry, overall attitudes among other students at the same stage may possibly be even more negative. With this information, we can target undergraduate training in a more specific manner in order to address these attitudes. Furthermore, it is important to foster the positive attitudes that have come forward in this project. Ongoing evaluation of the change of attitudes with education and/or targeted interventions is needed.

GMC standard theme 2 – Educational Governance and Leadership
▪ Trust systems are in place to detect and investigate patient harm involving or as a result of student activity ▪ Trust systems are in place to ensure informed consent is taken in areas where patients may encounter students ▪ Clinicians / teachers are appraised against their teaching
NTW has robust procedures in place to identify and respond to patient harm from or as a result of student activity. As well as identifying harm we seek to understand the views of

student involvement from their feedback. We also monitor all incidents where students might be harmed or distressed by their experiences on attachment.

Consent is sought in community, out-patient and ward environments before students meet patients. Consent is verbal and patients are informed that they can withdraw consent at any point without having to give a reason and that this will have no impact on their care or how they are treated.

All medical staff identifying teaching as part of their duties are appraised against this outcome via appraisal (consultants and career grade staff) or ARCP (training grade staff).

Planned initiatives:

Audit of appraisal for undergraduate clinical teacher roles.
Regular in-house staff development sessions for undergraduate teachers including assessor training.

GMC standard theme 3 – Supporting Learners

- Appropriate guidance and support was available outside of formal teaching
- Students were satisfied with the overall quality of the facilities for students.
- Teaching took place in appropriate settings and surroundings
- Good quality learning resources were available to support learning
- Access to IT facilities was adequate
- The programme of study outlined for the course was delivered

1. Facilities and surroundings

All scores improved in relation to facilities / resources. This reflects further investment by the trust in undergraduate student facilities at St Nicholas Hospital with access to both IT and refreshments.

Facilities and surroundings overall satisfaction 2016/17 (2015/16)

Question	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)
Stage 5	96.67%(64.7%)	76.67%(65.4%)	89.74%(78.9%)	97.62%(90.2%)
Stage 3	91.11%(75.6%)	93.88%(79.3%)	94.63%(93.6%)	100.00%(75.6%)

A new student room has been fitted out at St George's Park. This includes PCs and access to refreshments. It is going o be relocated later this year to increase proximity to junior doctors to allow for more opportunities for informal support.

Our longer term goal remains to establish a more permanent teaching facility on one of the main trust sites. This project has reached the next stage and the trust are currently considering plans within the grounds of St Nicholas Hospital with the aim of co-locating teaching facilities and the medical education team.

2. Learning resources

Feedback data for "Good quality learning resources (e.g. LSE, IT access, study guides) were available to support my learning' 2016/17 (2015/16):

	Tyne (SNH)	Tyne (G'head)	Northumbria	Wear (HWP)

Stage 5	86.67%	76.67%	79.49%	90.48%
Stage 3	62.00%	100.00%	91.06%	100.00%

The responses to this question were rather mixed and refer to a number of resources, many of which are identical for the students independent of location. It is therefore difficult to interpret the numbers and it is possible that we see a halo effect from perceptions about other aspects of the placement.

3. Access to IT

Students have had access to improved WIFI since last summer.
All students have a RiO training session on day one of their rotation, at which point they are provided with login details to gain access to the intranet and electronic patient records.

The question regarding access to IT has changed in the 2016/17 feedback and is now included in 'good quality learning resources (e.g. LSE, IT access, study guides) were available to support my learning'.

The Medical Education team are aiming to make more use of the LSE to provide better access to learning resources.

PCs have been purchased for a new student room at St George's Park.

Currently students have read only access for RiO and we are exploring altering this so students can also make entries on patient records, as long as they are countersigned/ validated by a responsible qualified professional.

GMC standard theme 4 – Supporting Educators

- Clinicians / teachers have time in job plans for teaching including educational supervision.

Staff with lead roles in undergraduate education/ teaching have PA time specified in their job plans. SIFT money continues to be aligned to teaching and we continue to budget for teaching fellow posts and have increased the time attached to the Northumbria base unit lead, so that now all base unit leads are apportioned 2 PAs in their job plan.

Due to a reorganisation of management structures within NTW this year, we have not been able to progress with plans to improve identified time for clinical undergraduate teaching for those who do not have identified lead roles and currently provide such teaching as part of their SPA time. Recruitment difficulties continue to pose a significant challenge in this regard.

Teachers are supported through training opportunities, including the faculty development programme.

At the trust's **2017 Medical Education conference** undergraduate medical education formed part of the programme with an update from the course director and a workshop on "How to plan a 6 week and 6 month SSC". The workshop was attended by 48 delegates, mainly consultant psychiatrists.

Feedback:
48.72% of attendees said that they don't currently offer an SSC but would now consider doing so.
61.90% said the workshop was useful to their role.

In October 2016 Dr Boddy and Dr Reckermann delivered a **joint psychiatry and primary care staff development day** focussing on undergraduate education, opportunities for integration, simulation and included MOSLER assessor training. The day was attended by 31 delegates, GPs and psychiatrists, and it received very positive feedback (response rate 16/31):

100% agreed or strongly agreed that the day's stated aims and outcomes were achieved for them.
88.3% agreed or strongly agreed that that they got what they wanted out of the day.
94.2% agreed or strongly agreed that the day was pitched at the right level.
94.2% agreed that the facilitators had very good delivery skills.

Teaching fellows and consultants are supported in developing their scholarship in medical education and sponsored to complete the **Postgraduate Certificate/ Diploma/ Masters in Medical education:**

For 2016/17 –
PG Certificate in Medical Education
4 teaching fellows
1 higher trainee doing special interest session in Med Ed
2 Consultants

PG Diploma in Medical Education
1 Consultant
2 teaching fellows

For 2017/18:
PG Certificate in Medical education:
6 teaching fellows
1 SpR doing special interest sessions

PG diploma in Medical Education:
1 consultant (part-time)

PG Masters in Medical Education:
2 teaching fellows
1 Consultant

New Initiatives:

"Training Trainees To Teach (TTTT)
Supporting trainees to improve the delivery of undergraduate medical education"
(Dr Helen Hargreaves, senior teaching fellow)

An in-house near-peer 'Training Trainees to Teach' (TTTT) course was developed to support NTW core trainees in their role as teachers to medical students attending clinical rotations throughout the year. TTTT offers sessions on bedside teaching, small group teaching, large group teaching and assessment. The number of sessions attended by individuals range from 1 to 4.

Results
All attendees identified that sessions met their learning needs, were interesting and prepared them for delivery of undergraduate teaching. They would recommend the sessions to other trainees.

Improving the skill sets and confidence of core trainees
Attendees' confidence scores were increased in all sessions, with mode increasing from 3 to 4.
The majority of responders suggested that since attending TTTT they had been more actively involved in the delivery of teaching to undergraduate medical students (75%) as well as to others (58%), would estimate their involvement in teaching to have increased (75%), the student feedback regarding the quality of their teaching to have improved (75%) and the feedback they receive for AoTs to have improved (73%).
11 responders also either agreed or strongly agreed that TTTT had improved their ability to deliver good quality undergraduate teaching sessions.

After some adaptation the sessions continue to run for 2017/18.

GMC standard theme 5 – Developing and implementing curricula and assessments
▪ The Trust has processes to ensure those undertaking summative assessments are appropriately trained ▪ The Trust has a system in place to provide educational supervision ▪ The Trust has an executive or non-executive director at board level responsible for supporting training programmes
The trust follows university guidance for the training of those completing summative assessments. Training is delivered to new assessors prior to them completing assessments. Feedback on the assessment process has been consistently high. Dr Boddy, Dr Owen and Dr Tim Strange (teaching fellow) created a MOSLER assessment video with a view to using it for MOSLER assessor training. This is used for in-house training at present and is currently under review by Dr Tim Smith with a view to uploading it to the university's Teaching Support Environment website and using it centrally for MOSLER assessor training. The mental health learning outcomes are under regular review and the base unit leads feed into this through participation the quarterly Psychiatry Implementation and Innovation Group, chaired by Dr Boddy in her role as Course Director for mental Health (with Newcastle University). Last year the group developed new inter-professional learning outcomes, a new perinatal psychiatry outcome (for the Women's Health rotation) and updated existing outcomes on eating disorders and culture. The group also provides opportunity for peer support and continuous professional development. In her role as course director Dr Boddy is currently contributing to the redesign of the Newcastle MBBS curriculum. With a voice in the design and implementation of the curriculum the trust is in an excellent position to ensure that outcomes are delivered and assessment meets the standards required. Changes in service provision and current challenges are also fed back into the design of the course. The Director of Medical Education (DME) reports to the Executive Medical Director who is the board level director with responsibility for the delivery of training programmes. The SAR and QIP are presented to the board as is feedback from quality visits. This is done usually by the DME and/ or other members of the medical education team present.

6.3 Simulation

Please describe how the LEP supports simulation activity, including engaging with the faculty of patient safety, clearly highlighting any challenges or good practice items

Postgraduate

We have been extending the use of simulation training over the last three years. Key elements linked to our increasing use of simulation has been to both appoint a medical simulation lead with nursing support and to develop a consistent approach to how the method is used. We have adopted the use of the diamond model for debriefs and have been teaching trainers this model so trainees can become familiar with a single approach. We now have a series of programmes many of which we see as good practice:

1. Simulation training in emergency psychiatry – this is a simulation training based programme aimed at CT1 trainees to introduce them to the principles of simulation training and debriefing. This covers a range of acute psychiatric and medical emergencies and hence is important in the area of patient safety.

2. Simulation training joint programme with paediatric trainees - we have been working alongside colleagues in paediatrics to develop simulation training that supports trainees in the assessment of risk in paediatrics following self-harm.

3. Simulation training in mental health act tribunals - this is a training package we have developed over three years, working alongside colleagues in Northumbria University. This covers both the delivery of oral evidence and preparation of reports. We have just started extending this training to support non-medical staff.

4. Use of simulation to improve communication skills – this is a package of training we have been using to help trainees develop their communication skills.

Undergraduate
We are incorporating simulation in both the ESR and EJR and have developed a new session for the current ESR.

The **ESR session on assessing capacity** involving a simulated capacity assessment of a joint psychiatry/ medical/ surgery case was rated extremely positively in 2016/17 and is being delivered again this year.

Assessing Capacity (144 responses)
99% of students strongly agreed or agreed that the session met their learning needs.
99% of students strongly agreed or agreed that the teaching was delivered at the right level.

99% of students strongly agreed or agreed that the standard of delivery was good.
99% of students strongly agreed or agreed that the session was interesting.
99% of students strongly agreed or agreed that the resources used for the session were appropriate.

Interview skills training with actors continues for both the ESR and EJR and receives continued positive feedback:

Interview Skills ESR (110 responses)
97% of students strongly agreed or agreed that the session met their learning needs.
95% of students strongly agreed or agreed that the teaching was delivered at the right level.
95% of students strongly agreed or agreed that the standard of delivery was good.
97% of students strongly agreed or agreed that the session was interesting.
94% of students strongly agreed or agreed that the resources used for the session were appropriate.

Interview Skills EJR (198 responses)
97% of students strongly agreed or agreed that the session met their learning needs.
96% of students strongly agreed or agreed that the teaching was delivered at the right level.
96% of students strongly agreed or agreed that the standard of delivery was good.
97% of students strongly agreed or agreed that the session was interesting.
94% of students strongly agreed or agreed that the resources used for the session were appropriate.

New initiatives:

In order to move to more immersive simulation, a **new simulation session** is being piloted during this year's ESR (2017/18). This session simulates an out-patient environment in which the students have to complete brief assessments and negotiate a suitable management plan; the session it aims at improving the student's clinical reasoning skills.

We are evaluating the session in the current ESR, adapt it accordingly and present results in next year's SAR.

The teaching fellows are joining a project with the Wear base unit and are creating a psychiatric simulation scenario for the "Wear-y nights" **simulation event** in November 2017 – this is an exciting opportunity to create more high fidelity simulation which is relevant to future junior doctors and promotes horizontal integration between mental health and other rotations. They are creating and will help to facilitate a scenario on assessment and immediate management of suicidal ideation. The Northumbria base unit are also considering the use of these psychiatric simulation scenarios.

APPENDIX 1
(SAR Dashboard, excel file)

APPENDIX 2
Summary (self-assessment) against the standards by theme

Further to the completion of this section (previously SAR section 3 in 2015) and (appendix 2 in 2016), this section will continue to be an appendix, with changes highlighted on an annual basis.

Please ensure that:

1. That the narrative includes a list of associated trust policies which support the standards

2. That any further changes from last year's submission are highlighted

Narrative and description of how the standards are being met

Please describe how your organisation meets each standard. Remember; the supporting departmental / unit reporting information does not need to be repeated here. An overall narrative along with some organisational wide and departmental / unit examples may support the standard having been met overall. You may wish to reference to the supporting departmental / unit information.

We have in the remainder of the report highlighted in bold the information that is new for this reporting year

GMC standard theme 1 – Learning Environment and Culture
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
R1.1 and R1.2 *The organisation must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or education and training, openly and safely with fear of adverse consequences. Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.* The following measures were reported in 2015 and 2016 SAR and these processes are unchanged. • In junior doctor induction, there is a talk about the professional roles and responsibilities of the doctor. • The Trust has a system for reporting incidents and a whistleblowing policy (NTW (HR) 06). Guidance is available in the NTW trust intranet for both processes. • Higher trainees are encouraged to spend a day a week with the safety team and to attend a serious untoward incident panel. • All trainees with any involvement in serious untoward incidences (SUI's), are encouraged and supported to attend the after action review and any incident panel in order to become familiar with this area of clinical governance. • Reflective practice training is being offered now to GPs, foundation doctors as well as core trainees. A number of systems are in place to allow trainees to raise concerns about the standard of care or education and training. They can do so through their clinical or educational supervisors, the college tutor, or raise issues directly to the Associate Medical Director of Postgraduate Medical Education or the DME. The Guardian of Safe Working is Dr Tocca. We respond to all patient safety issues reported by trainees. **90-95% of trainees (over 4 Trusts) reported knowing how to raise concerns about patient safety in the School Survey. To date we have not been able to acquire information at a trust level however more than half of all trainees in the four trusts come from NTW.** **S136 Audit** **An initial safety audit of S136 suites across the Trust was finalised and remedial environmental works completed. The audit found significant improvement. The trust safety team have now rated risks as low and no further action is required.** *R1.3* *Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.* Serious Untoward Incidence (SUI) Process-described in SAR report 2015. In line with GMC requirements, we have a system to identify when trainees are involved in SUI's, review their involvement in the case and provide support as needed. This process ensures that all cases of trainee involvement with an SUI are reviewed by a senior clinician and administrative member of the medical education team. Where the trainee involvement is felt to be significant they are asked to be involved with the subsequent investigation and supported through this by their educational supervisor. This information is sent to HENE.

In the reporting year to August 2017, there were 100 SUIs in the Trust. 23 trainees were involved in the care of the patient close to the time of the SUI. There were no concerns expressed about the performance of any of the trainees named in these SUIs.

R1.4
Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong-known as their professional duty of candour and help them to develop the skills to communicate with tact, sensitivity and empathy.

Duty of candour is covered in induction.
All trust appraisals include reference to duty of candour.

R1.5 and R1.6
Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient's safety and care, and on education and training. Awareness of processes for clinical and educational governance and local protocols for clinical activity.

The college tutor quality assures posts every 6 months to ensure the learning environment and culture in each post is safe for patients and learners as described under theme 2.

Feedback is sought on education and training and results are presented throughout the report. Systems are in place to allow trainees to give feedback on standards of patient safety also described elsewhere.

With the support of college tutors we have established local trainee fora in each locality.

The Guardian of Safe Working Trainee forum is up and running with representation from medical education, the LNC, the BMA and we also have high numbers of junior doctors attending. Patient safety concerns are raised at this forum and appropriate action is taken.

R1.7
Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.

There are ongoing challenges regarding recruitment and retention of staff within the trust. We take a proactive approach to managing this situation to maintain safe levels of medical staffing both in and out of hours using a number of measures:

- The trust will employ locum doctors to fill gaps.
- There is a described process for gaps in the on-call rota when there is an unexpected absence.
- There is a recruitment strategy including recruiting overseas doctors
- There is a feeder scheme aimed at supporting trainees into core training.
- We have been flexible in our use of training money from vacant posts to employ other staff to reduce medical workload
- **We have employed 2 trainees through the RCPsych MTI (medical training initiative) scheme**

- We are working with partners to encourage HEE to look at ways of supporting recruitment to the North East.

GMC Survey 2017:
Workload: mean satisfaction for workload was 61.38% (5 year average 57.36%). The national mean is 47.20%.

R1.8
Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support must be outlined to the learner and supervisor. Foundation doctors must at all times have on-site access to a senior colleague. Medical students on placement must be supervised.
R1.9
Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.
R10.1
Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.

The faculty development programme is structured to provide support and training for supervisors taking up educational roles. This sits alongside other measures including an individual meeting with new consultant supervisors to ensure they are aware of their roles and are aware of the support and development that is in place.

The GMC National Trainee Survey, 2017:
Clinical Supervision score was 92.96% (5 year average 92.3%) is above the national mean which is 90.39%.

Educational Supervision:
89.84% satisfaction, (5 year average 91.66%), national mean 88.31%

School Survey 2017
Clinical supervision
85-88% of trainees (over 4 Trusts) felt they had the required quality and amount of clinical supervision.

In order to protect patients and trainees we have had to take robust action where there were concerns that not enough suitably qualified senior medical staff were available to provide safe levels of clinical supervision. For example, due to difficulties recruiting consultant staff in the community in Northumberland, one core post was reconfigured to being purely a peri-natal post. We have evaluated the change and in the last round of feedback, this post received a 10/10 rating.

We had concerns about the lack of consistent consultant cover onto an old age ward at St George's Park. Therefore trainees were moved from this ward (both GP trainees) in order to guarantee ongoing safe levels of supervision and to protect trainee experience. We have worked closely with the trust on working towards solutions to safely manage the patients on the other ward and once there was some clarity around supervision, we recruited a locum doctor to cover this gap using the training budget.

We continue to closely monitor the situation, and trainees to date have not reported any problems gaining access to timely and appropriate levels of supervision.

R1.11
Doctors in training must only take consent for procedures appropriate for their level of competence. Learners must act in accordance with GMC guidance on consent.

ECT is the only procedure requiring consent. There is an ECT policy which gives clear guidance on consent. There is an ECT rota, so that trainees can obtain experience in this area.

R1.12
Rotas
Appropriate supervision is available on-call.

GMC Survey 2017: Clinical supervision out of hours 90.88% (5 year average 89.42%), higher than the national mean, 89.20%.

Rotas have been re-designed in line with the new junior doctor contract. The first on-call system has been a full shift system for some years. North of Tyne, a full shift system is being piloted with a reduction in second on call cover from two to one ST trainees. To date feedback has been mixed about the change. The new system has not led to any patient safety issues or workload issues. Supervision for junior doctors and the opportunity for WPBAs out of hours has improved. Some trainees who are not in favour are worried that the shift system reduces their time at work during the day and may impact on training. On balance, the argument both from a financial perspective to protect the pay of ST trainees on the new contract, and from a supervision perspective is in favour of the new model. Data regarding workload in Northumberland and South of Tyne is being gathered with a hope to expand the geographical area covered. The addition of a regular second tier shift may improve consultant recruitment, which has been a problem in this area. Improvement in supervision is likely to be magnified in Northumberland and South of Tyne where there are few higher trainees currently.

R1.13
Induction
Induction is based on the standardised format followed across the Trust as indicated by the National Patient Safety Agency.

In the GMC Survey 2017, 82.81% were satisfied with induction (5 year average 85.81% and national mean 81.92%). The breakdown is given below. Questions about induction include questions about how well trainees are inducted into their role by their consultant supervisor. Issues with the stability of the consultant workforce affected the sites highlighted in pink and this may have had an adverse impact on scores.

	Benton House	CAV	RVI	HWP	MWM	Prudhoe	SGP	SNH	WGP
Induction	84.38	84.38	89.58	79.58	72.50	72.92	72.22	89.06	93.75

R1.14
Handover

The nature of handover arrangements in psychiatry result in mental health trusts scoring lower than average. In the GMC Survey 2017 our score was 66.54%, (5 year

average 56.22%, national mean 70.15%). In the School Survey 70-75% of trainees (over 4 Trusts) felt that handover occurred effectively and in a manner that was appropriate to the nature of the work.

Looking at the survey results in more detail, 6.75% of trainees identified that handover arrangements did not always ensure continuity of care between shifts. 13.51% identified that handover did not always ensure continuity of care between departments.16.21% identified that not all members of the MDT were included in handover.

Through our local processes, we have identified three separate issues with handover.

1. **Trainees have repeatedly reported that new patient admissions whilst handed over to bed managers and nursing staff are not handed over the junior doctors. They have reported that as a result, adequate information about new patients is not given to them. We have communicated this to medical and nursing staff including crisis teams without an improvement. We have now written to bed managers requesting that as part of the bed manager guidance, admitting clinicians are requested to handover both to medical and nursing staff. This will be kept under review.**

2. **Handover from nursing staff to doctors. A trainee led audit of handover was carried out in over a two week period in 2016. The audit found that handover to doctors was not conducted using a structured tool. The recommendations from the audit are being discussed. The use of the SBAR tool has been suggested.**

3. **A more minor problem arises sporadically where trainees are not meeting as per guidance to carry out handover. When this arises, we ask local college tutors to address the issue.**

R1.15
Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.

In the GMC survey 2017, satisfaction with feedback was 81.62%, (5 year average 86.03%, national mean 76.76%).

R1.16
Protected time for learning.

85-88% of trainees (over 4 Trusts) were happy with access to study leave in the School Survey. 70-75% felt the local in house postgraduate training was of a high quality.

There is a study leave guide to aid trainees. Study leave is centrally managed by the LET. Core trainees are required to attend MRCPsych training and to use the study leave budget for this.

There was a red outlier for study leave for Hopewood Park. Looking at the breakdown of the results, it would appear that some of the respondees had problems obtaining prospective cover or having flexibility with leave. Some trainees were unsure of processes around study leave although there is a guide made available at induction. Again we have been proactive in recruitment to gaps in posts and we have appointed a teaching fellow who provides additional input into clinical area.

GP trainees also have a study leave budget.

R1.17
Organisations must support every learner to be an effective member of the multi-professional team, promoting collaboration between specialities and professions.

There is no change from last year:

- Trainees work as part of a multi-professional teams. They are involved in the Care Programme Approach process, MDT meetings and ward MDT. Teams typically include doctors, nurses, social workers, support workers, occupational therapists, and clinical psychologists.

- There is a quarterly Mental Health Specialty Group, which focuses on research in the region. This group gives an opportunity for sharing good research practice and experience and because invitees are not confined to psychiatry will hopefully foster collaboration.

- Neurology and GP colleagues have been invited to attend the Regional Teaching (monthly lecture series). New joint neurology, psychiatry joint teaching programme has been established in Newcastle.

- We have established regular Schwartz Rounds, these are a multidisciplinary forum designed for staff to come together once a month to discuss and reflect on the emotional and social challenges associated with working in healthcare. This is a good example of multi-professional learning which promotes the culture of learning and reflection

R1.18
Organisations must make sure that assessment is valued and that learners and educators are given adequate time to complete the assessments required by the curriculum.

Adequate experience is rated 81.03, (5 year average is 82.30%, national mean 79.02%). Adequate experience was a red outlier for the GP programme last year but now scores within the mean.

R1.19
Organisations must have the capacity, resources, and facilities to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.

Trainees are using the e-portfolio (90-95% of trainees across 4 Trusts reported being able to access the e-portfolio when required).

In the School Survey 70-75% of trainees across 4 Trusts said access to office space is sufficient to allow them to perform their duties.

All on-call rooms across the trust have been reviewed. Minimum standards have been set and new furniture and equipment has been ordered as required.

R1.20

Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.

Psychiatry curriculum does not have technology enhanced learning opportunities. We support access for GP trainees.

As part of the trainee development programme four simulation in mental health (SiMH) sessions were run with 17 trainees attending in total.

R1.21
Organisations must make sure learners are able to meet with their educational supervisor as frequently as described in the curriculum.

Satisfaction with educational supervision remains high**.**

In the GMC survey 2017:
Educational Supervision: 89.84% satisfaction (5 year average 91.66, national mean 88.31%).

R1.22
Organisations must support trainers, supervisors and learners to undertake activity that drives improvement in education and training to the benefit of the wider health service.

We deliver a Faculty Development Programme (theme 4), we encourage supervisors and appropriately staged trainees to link with Newcastle University School of Medical Education staff development programme.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Over the report period of the 71 ARCPs for speciality trainees there were 4 outcome fours. There were 15 outcome threes.

GMC standard theme 2 – Educational Governance and Leadership

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

NTW has an established educational governance system key elements of this include:

- Defined roles and responsibilities for trainers at all levels
- Defined process to quality manage individual training posts and feed this back to trainers. This process involves regular review of training posts (foundation 2 yearly, core speciality and GP 3 yearly) looking at feedback from trainees through end of post survey and mid and end of post interviews with the college tutor. This review is done jointly with college tutors, trainers and trainee representatives. The trust established a similar process for higher training posts; this includes broader feedback across all posts rather than individual feedback.

In 2016/17 this process has been strengthened by the introduction of a new quality lead. The quality lead (band 5 post) accompanies the college tutor and foundation tutor in mid post reviews. This has improved the flow of this feedback both to trainers and the medical education team. We are aiming to use this increased support for tutors to improve standardisation of information gathering, as well as

improve sharing of good practice.

- Processes in place to collect, review and respond to other quality metrics including annual review of GMC trainee and trainer survey (relevant evidence is shared with trainers, trainees and school as well as executive team including CEO), review of school of psychiatry survey (again widely shared including with senior management), feedback from trust induction and training events delivered by the trust.

Having a dedicated quality lead post has allowed us to completed more detailed analysis of the range of quality metrics available allowing us to identify and respond to areas of need in a timely fashion, as well as better understand the data.

- Variety of live opportunities for trainees to raise concerns about training (meetings with clinical and educational supervisor, college tutor, trainee fora, the education committee meetings and through written feedback) and system in place to address this established with joint involvement with trust and school.

The appointment of the Guardian of Safe working and the establishment of a trainees forum meeting bi-monthly has been an important development in the last year to provide an added forum for trainees to raise concerns about training opportunities, as has exception reporting.

- Regular report to trust board from DME providing update and feedback about quality of medical education delivered by the trust.
- Approved job descriptions for training posts reviewed regularly as part of the quality management process ensuring these mapped onto appropriate curricula

As part of the process of developing work schedules all job description have been reviewed in the last year and updated in line with curriculum and service changes

- Collaborative and open approach to quality visits from external bodies including HENE and school of Psychiatry, sharing findings and any changes implemented following these with all parties with an interest including trainees, trainers and trust management
- We measure the quality of our educational programmes and present data on this throughout the report.
- New governance systems for college tutors with college tutor posts now funded (at 0.5 to one PA per week). There is a new system for appraising college tutors in their roles with information provided for annual appraisal.

(*R2.1, 2.2, 2.4, 2.6, 2.7, 2.8 & 2.9*)

In order to ensure educational resources are allocated and used for training there is a separate doctors in training budget with the budget holder being the DME. There is additionally trust agreement that all trainers have dedicated time (0.5 SPA) for educational supervision. Over the last year there has been an important piece of work done within the Trust looking at Trust use of SIFT funding, which now passes through the Medical Education Department. This improves the governance arrangements and should improve the quality of teaching and student experience by aligning financial resource to those who deliver it. Concrete example of the use of this money has been the appointment of teaching fellows, improvements in student facilities and educational resources.

In the last year there has been an increase in the number of teaching fellow posts from five to seven. There has also been the appointment of three additional medical education leads, each with one session of time,

(*R2.10*)

There is medical education representation at the Corporate Decision Team and Group Business Meeting ensuring that the needs of trainers and trainees can be considered as services develop.

Trainee representatives are included in the educational committee and discussions around development of workforce policies and practices involving trainees. There is a new trainee representative for International Medical Graduates.
(*R2.3*)

All trainees working in the trust have a named clinical supervisor who provides at least one hour of educational supervision each week and at the start of each post they and their supervisor complete an educational agreement. Training posts are approved and have job descriptions mapped onto the appropriate curricula. All foundation, core and GP trainees also have an educational supervisor who meets with trainees regularly to support their training, help them reflect on feedback and prepare them for ARCP's. For higher speciality trainees the clinical supervisors also take the role of educational supervisors in line with School of Psychiatry guidance. The Trust job plans and provides training for all both these roles as well as supports appraisal in these roles. This training covers both educational and clinical supervision as well as line management responsibilities ensuring training occurs in a safe clinical environment.

2017 GMC trainee survey data scores demonstrate educational governance as being robust. We scored above the national mean with a score of 75.4 (national mean 73.3) on the educational governance rating, and also above the national mean on educational supervision with a score of 89.8 (5 year average NTW 91.7, national average 2017 88.3).

Similarly the trust scored above the national average in GMC survey questions on clinical supervision (93.0, national mean 90.4 and NTW 5 year average 92.3), clinical supervision out of hours (90.9, national mean 89.4 and NTW 5 year average 89.4) and reporting systems (75.8, national mean 75.4 and NTW 5 year average 76.6)
(*R 2.11, 2.14 & 2.15*)

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

All trainees have their progression regularly reviewed with their clinical and educational supervisors and annually as part of their ARCP. The trust ensures trainers have the time and training to provide this assessment and feedback. Opportunity for getting feedback and having WPBA's is monitored for each post as part of the quality management process described above.

The trust has a specific policy to support trainees with performance concerns, this is done in a supportive way with input from the trust, HENE and LET involved as needed. This is designed to specifically look at both learning needs for trainees, health concerns where present and patient safety. In all cases that are complex or impact on patient safety there is Director level involvement from the medical education team. In the last year we have had 5 trainees with performance issues that were raised to level 2. Management of two were led by the trust with the support of the LET and the school. The LET led on the management of the other three. Part of the medical development lead's role includes a supportive role for trainees with performance issues which sits separately from management structures.

The trust also has an established system for reviewing trainee involvement in SUI's, with dedicated medical and administrative input to ensure cases are thoroughly reviewed and any actions followed through and this information shared with HENE.
(*R 2.12, 2.16 & 2.17*)

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Recruitment is managed by the School of Psychiatry with the support of the LET in a process largely centrally managed by the Royal College of Psychiatrists. The Trust supports this process through supporting trainers in being involved in recruitment.
The Trust supports all trainee requests to work less than full time when this supported by HENE/LET and similarly trainees with additional health needs. As well as making any recommended adjustments this includes the employment of additional locum staff to ensure there is not undue clinical demand.

Allocation of individual training posts is led by training programme directors, in the case of core psychiatry training posts there is input from the trust ensuring all relevant information to inform this decision is available.

The trust as an employer and host of trainees complies with employment law, Equality Act and Human Rights Act monitored through our medical staffing department which following recent organisational changes is working increasingly closely with the medical education teams.

The principles of professionalism are key to core trust values and this is emphasised through a training session on professionalism delivered at induction.
Industrial action: we have liaised with the LET, BMA and medical staffing to support trainees and assure patient safety during periods of industrial action affecting junior medical staff.

Within the last year with the support of the school of psychiatry we have been working with trainees to improve transparency around post allocations. This is a process managed jointly with the school and clear guidance is now available for trainees outlining the process.

We have over the last year appointed a lead on supporting IMGs and developed a program of support for doctor's new to the UK in order to support them adapting to the UK, NHS and training systems.
(*R2.19 & 2.20*)

GMC standard theme 3 – Supporting Learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

The medical education department runs a number of centrally organised training programmes as outlined below.

We ran a number of Trainee Development Programme sessions over the reporting year.

13 trainees attended Formative Assessment of Communication Skills (FACS).

7 trainees attended a Reflective Practice session.
100% of trainees said the aims and outcomes of the session were definitely achieved.

100% of trainees said they got what they wanted out of the session.

As part of the trainee development programme four simulation in mental health (SiMH) sessions were run with 17 trainees attending in total.
92% of trainees strongly agreed that the day met their learning needs.
54% of trainees strongly agreed that the simulations were delivered at the right level for their stage of training.
100% of trainees strongly agreed that the standard of debriefing was good.
85% of trainees strongly agreed that they would recommend the training to others.

Mock CASC Exam
67% of trainees were very satisfied or satisfied with the mock CASC.
67% of trainees said there were enough stations.
100% of trainees said the actors were good and felt true to life and CASC.
100% of trainees said there was a good balance of topics covered.

Higher Training Day
A leadership and resilience day was run for Higher Trainees and there were 10 attendees. Trainees were asked to rate the delivery and content of both the leadership and resilience sessions. Leadership scored an average of 91 and resilience 92.

GP training
A new training programme set up specifically for GP trainees started in March. Sessions included Psychiatric 10 Minute Consultation, General Adult Services, Prescribing, CAMHS, Old Age Psychiatry in GP, Primary Care Psychology and LD in GP. Overall 18 trainees attended these sessions.

Feedback:
'I must say that the teaching programme is quite robust and outstanding'
'The consultation skills session was excellent and very GP focused, i.e. consults in 10 mins with common presentations'
'Very well designed and targeted to GP training. Good role play and feedback'

CASC preparation course. The feedback from the course was positive. We have run two preparation courses in the reporting year and one mock examination. The feedback presented is from the most recent course.

Candidates

100% of attendees strongly agreed or agreed that the CASC course met their learning needs
83% of attendees agreed that feedback arrangements each evening were appropriate
83% of attendees said the timing was the course was appropriate
100% of attendees said the number of sessions was just right
100% of attendees said the sessions were just about the right length
83% of attendees said that the topics covered were sufficient

Assessors

30% of assessors were helping out with the CASC course for the first time
100% of assessors said they would help out with the course in the future
100% of assessors said the information they received ahead of time was sufficient
90% of assessors strongly agreed or agreed that they enjoyed the evening(s) assisting with the course
80% of assessors had training in examining CASC before

Each local area hosts its own in-house training. Local teaching overall is rated at 68.24% (5 year average 66.92% and national mean 64.60%).

There was a dip in the quality of teaching rated in one area, CAV, which may have related to lack of protected time to attend teaching linked to cover issues on site. The college tutors collected local feedback which was more positive. 80 % people rated the quality of case presentations as good and 70 % rated the quality of journal clubs as good. The common theme, which came out was related to the timing of the meeting and people wanted to see more senior clinicians attending these meetings. The local college tutors are using the feedback to improve the course.

International Medical Graduate Initiative
A new lead has been appointed and has developed a package of support:

- **Enhanced IMG induction day which includes a GMC workshop. Trainee representatives are also involved to help new arrivals feels welcome and to ensure that they are included on trainee social networks.**
- **IMG social event, befriending and 'finding a buddy'**
- **IMG trainee forum**
- **IMG bespoke training days, including communication workshops and coping with stress.**

GMC standard theme 4 – Supporting Educators
S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.

Within NTW there are clearly defined educational roles with trainers appointed to these based on their experience. For each training role there is support available through the education faculty for trainers in the form of induction, CPD, trainer forums and appraisal of educational roles.

In 2016/17 in line with the increased job-planned time for local postgraduate educational leads we have implemented formal appraisal of the role within the department as an addition to the whole role appraisal that was already in place. We have supported college tutors with local budgets for training and provided additional support from the quality lead in post reviews. This additional support has been accompanied by greater clarity in expectations and appraisal of performance.

We have recently increased the support of local undergraduate educational leads in relation to time available and increased numbers of teaching fellows. Over the next year we aim to develop the appraisal process of these roles.

Enhanced consultant induction programme aimed at supporting new consultants in their role. Part of this includes all new consultants meeting with the DME in order to discuss trust medical education roles broadly as well as any specific roles.

We deliver an established Faculty Development Programme, the courses have Northern Faculty of Medical Education approval:

- Educational supervision

- Line management of trainees
- Work placed based assessment training
- Assessment training (feedback given elsewhere)

In 2016/17 this program has been developed with the addition of two new courses the first is a refresher course for established clinical and educational supervisors and covers preparing trainees for their ARCP, updates on the contract changes and supporting trainees in difficulty. We have also established a process where the DME and AMD postgraduate education visit local consultant meetings on a six monthly basis as part of a process to build links with trainers and allow local discussion on training issues and priorities.

In addition to these new courses over the last year we have also run two separate training days the first for GP trainers focussing on portfolio training done alongside colleagues from the GP scheme and the second focussed on Foundation trainers.

Summary of Faculty Development Program 2016/17

Supervising your trainee
Ran twice during reporting period.
9 people attended in October 2016. 100% said their objectives were met.
6 people attended in June 2017. 100% said their objectives were met.

Line Management of trainees
Ran twice during reporting period.
9 people attended in October 2016. 100% said their objectives were met.
6 people attended in June 2017. 100% said their objectives were met.

Work Based Assessment Course
Ran once during reporting period.
9 people attended. 80% said their objectives were met.

Supporting Your Trainee with Audit
Ran once during reporting period.
3 people attended. 100% said their objectives were met.

Trust Medical Education Conference 25th May 2017
67 attendees
Updates in Medical Education – Undergraduate, Postgraduate and Recruitment.

There were workshops on Confidentiality, How to Plan a 6 Week and 6 Month SSC and Simulation and Debriefing Skills.

Matthew Critchlow ran a session on Promoting Individual Resilience in the Workplace.

Trainer Refresher Course
Covers preparing your trainee for the ARCP, update on the new contract and supporting trainees in difficulty.

ARCP Assessment for GP Trainers
Ran once during reporting period.
Feedback taken by the GP scheme.

Foundation Trainers Forum
Ran once during reporting period

8 people attended. No feedback.

We run a bi-monthly education committee attended by trainers from each locality, members of the medical education development and workforce team as well as trainees and representatives from the school of psychiatry. This allows not only sharing of good practice but also supports trainers in delivering a consistent approach to training across the trust.

It is of note that in the GMC trainer survey from 2017 NTW trainers score was a positive outlier for the parameter of trainer development (76.69). Scores for support for trainers (73.78) and increase from 69.64 in 2016 and 5.28 above national average. It is of note that the overall trainer satisfaction score was high in the trainer survey at 79.39%, compared with a national average of 71.87.

(*R4.1, 4.2, 4.3, 4.4 and 4.5*)

We have a local process to support trainers to be appraised in their training role. This process outlines the four specific training roles outlined by the GMC and how evidence can be mapped to GMC standards. Trainers and appraisers are provided with a guide describing the evidence that can be presented and we support this through both providing appropriate CPD and feedback on training roles.

The trust appraisal online tool SARD has been adapted to support this, with the guidance embedded into the system.

Trainer appraisal in their education role in now monitored centrally through the education team so this can be reported back to the GMC via HENE.

We have completed an audit of trainer appraisals, looking at 20 randomly selected trainer's most recent appraisal. This showed 100% of trainers had their training or education role identified in their appraisal, and 100% have presented evidence relating to their training role (100% have evidence of relevant CPD, 94% had feedback from their role as a trainer, 71% had evidence of reflection on their role).

It was noted however that only 82% of appraisers had commented on the appraisee training role, with only 76% providing feedback on this. It is notable that 71% of trainers had a training or medical education focussed item in their PDP.
This audit is encouraging in relation to trainers although shows some room for improvement with appraisers. In the last year we have delivered specific training for appraisers on completing appraisals of educational roles. We have also issued new guidance on this to appraisers and appraises in line with GMC standards.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

NTW has in the last year updated its job plan policy and the medical education team have worked closely with clinical managers and executives to ensure that protected time for training remains explicit within this. The policy states that all clinical and educational supervisors need to have 0.5 SPA for supervising a trainee, if they supervise an additional trainee this increases by a further 0.25SPA. Audit of job plans carried out in 2016 demonstrated that this standard was met.
In additional to this job planned time for supervisors other educational roles are appropriately supported through job planned time as well as administrative resources. The educational faculty has continued to grow over the last year with three new lead roles developed, each with a session of time and the expansion of teaching fellow numbers from five in 2016 to seven in 2017.

Having developed a new education centre in Hopewood Park in 2015 we as a trust are now in the process of developing a new education centre for the northern part of the trust which will be based at St Nicholas Hospital.

GMC trainer survey feedback demonstrated that NTW trainers scored above the national average for time given for training, with a score of 65.3 (national average 56.28) and resources for trainers 79.65 an increase from 75.82% the year before (national average 70.59).

GMC standard theme 5 – Developing and implementing curricula and assessments
S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates. (N/A for Postgraduate) **S5.2** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Trainees receiving training within the trust are all delivered an induction which includes induction into educational opportunities and expectations as well as clinical ones.
We work closely with the schools of psychiatry, medicine and primary care to ensure posts can deliver the curriculum and the necessary experience. We work closely with trainers to ensure there is an appropriate balance between training and service needs, and all trainees have weekly timetabled educational supervision, and good access to clinical supervision. Trainers are able to attend both local postgraduate teaching programmes as well as their programme central teaching (MRCPsych/GP/Foundation).
As noted above in the report GMC survey, school survey and ARCP outcome data supports that this is done well.

The nature of both psychiatry and rehabilitation medicine means that trainees are given opportunity to work in teams and we ensure trainees have adequate time in each post to achieve this, ensuring all trainees have at least four months WTE in their post.

The GMC trainee feedback scores for induction show that we rate above the national average, scoring 82.8, compared to a national average of 81.7. We are however aware that this score has dropped in the last year in comparison with our five year average (85.8) and we have established a group to review this over the next year.

We have over the last two years made significant progress in developing the opportunities for trainees to achieve appropriate experience in emergency psychiatry through developing a series of local arrangements. Audit of this has demonstrated this has been successful and the GMC survey broader data on curriculum coverage 76.9 (national average 76.0) and adequate experience at 81.3 (national average 79.0) supports this. Finally the GMC trainee score looking at workload is a measure we are pleased to have increased in and be well above the national average despite the pressures on recruitment, demonstrating our ability to ensure trainees are not having training opportunities impacted adversely by service pressures; NTW 2017 score 61.4, national average 47.2 and NTW 5 year average 57.4.

Despite these encouraging feedback scores we are aware that there is significant variation across different services and there have over the last year been acute areas of difficulty in recruitment that have impacted on trainees significantly. We are pleased with our ability to identify these issues promptly and have been able to work

with clinical service managers to address these problems using a variety of measures including looking with multidisciplinary teams at how tasks can be delivered, identifying additional medical resource through locum agencies and on one occasion adjusting trainee service remit to protect training
(*R 5.9*)

Supervisors all have appropriate training in both assessment and appraisal so they can deliver the college described assessments. Along with the school of psychiatry provide direct feedback to trainers about the quality of their assessments in supervisor reports. This along with requiring them to attend ARCP panels as part of their trainer appraisal and providing supervisor training in appraisal and feedback is all aimed to increase the quality of assessments.
(*R5.10 & 5.11*)

HEE standard 6 – Developing a sustainable workforce

6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.
6.2. There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.
6.3. The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.
6.4. Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

HEE NE Guidance:

HEE NE guidance:
Examples of workforce strategies being used throughout the Trust or within individual departments/training programmes where planned training delivery (e.g. as part of new JD contract 'job plan') for individual or groups of trainees is protected from service pressures (e.g. acute or predictable rota gaps) through the use of non-training workforce to deliver the service (e.g. Consultants/Trust Doctors providing acute cover, non-medical staff providing service).

For this theme please provide supporting evidence/information regarding your Trust's medical workforce strategies to balance the needs of service provision whilst protecting training delivery at a departmental level.

For example, strategies to increase the proportion of trained staff (medical or otherwise) delivering service on individual rotas/service areas (e.g. use of Consultants/Trust/MTI Doctors in providing resident on call to increase overall numbers in any rota tier, progress on implementation of new JD Contracts to define guaranteed training element 'job plans', examples of how training is protected when rota gaps occur in the short and long term)

In this theme for the dashboard we would be looking for self-rating of each department/programme group in terms of their overall ability to deliver in parallel both a 24/7 safe clinical service and high quality training for all staff in training posts. The descriptors for this overall departmental workforce status will be:

'Sufficient' - planned training for individual trainees is rarely affected (<monthly) as most acute and predictable service gaps are reliably covered by the non-training workforce

'At risk' - planned training for individual trainees is regularly affected (>=monthly) as acute or predictable unfilled service gaps cannot be reliably covered by the non-training workforce

'Inadequate' - planned training for individual trainees is frequently affected (>=fortnightly) as acute or predictable unfilled service gaps cannot be reliably covered by the non-training workforce

Recruitment into training posts is currently managed directly through national and local recruitment processes which NTW supports but does not lead on. NTW provide a number of staff to support these process, we have had staff involved in both national and international recruitment processes. All staff involved are supported in this role both with access to appropriate training and time to be involved.

As a trust we recruit a number of junior doctors directly through both our feeder scheme, as LAS doctors and as teaching fellows. For all these trainees we have followed trusts processes and procedures which are consistent with national regulatory standards.

In 2016/17 in addition to the above additional trainees we have expanded teaching fellow numbers, recruited to a research fellow post, recruited two doctors on the MTI scheme and recruited a range of GP and other trust post doctors directly to help fill vacancies, over the reporting year we have had seventeen doctors employed directly through the trust working to support vacant training posts.
(*6.1*)

The tracking of medical trainees through training programmes is something we have been doing for a number of years as a trust. The nature of psychiatry training programmes is such that this is best done alongside the school of psychiatry who can provide a broader overview. In order to achieve this we work with the school and colleagues in TEWV through a workforce planning group to look at patterns of progression, recruitment and retention.

Within the trust we monitor progress through core training using ARCP outcomes and also monitor progression from core training into local higher training and into trust consultant posts. These figures show that over the last five years we have had on average five trainees per year moving from the NTW element of core training into higher training in the region, this represents around 50% of the trainees progressing through core training.

We also monitor local exam progression rates, we are particularly pleased with the improvement in CASC success rates which last year was well above the national average. We have over recent years been focussing much of our trainee support around this so we will continue to monitor this to see if this improvement sustained

In the last year 18 trainees passed the CASC exam.

We have continued to offer a 'Feeder Scheme' that is aimed to support trainees in getting into speciality training, this scheme has over the last eighteen months supported five trainees, with four of these moving into core training or SAS posts. We are also directly employing one trainee who is on the core training scheme but the LET declined to employ due to previous employment factors.
(*6.2, 6.3 & 6.4*)

We have for a number of years had an enhanced induction programme for all new consultants and SAS doctors which has a focus on some of the non-clinical roles of senior doctors and how doctors can be supported in this. We have a mentor programme available to all new consultants and SAS doctors joining the trust. We also have a system in place of exit interviews when any consultants or SAS doctors leave the trust in order to identify any factors that may contribute to this.

For 2016/17 the new consultant enhanced induction programme remains in place. We

have in addition to this developed some specific training for higher trainees as they approach becoming consultants. This training has developed from a program we developed some years ago which was focussed on successful appointment into consultant posts. The focus has expanded with a program that is now split over three days, (a two day residential event and a separate one day event). One day remains devoted to preparing for consultant interviews and presentations, in addition however we also now include training on NHS/health care structures and systems, leadership skills, managing change and developing resilience. These events have been well attended and had excellent feedback
(*6.5*)

We reported in last year's SAR details of our workforce strategy along with an overview of the current and projected medical workforce situation. The background information has changed little as described below:

As a trust we have been reviewing our workforce strategy. The medical education team have been heavily involved in developing the medical workforce strategy This strategy is a key component of the broader workforce strategy in light of the significant recruitment challenges we currently face and are projected to continue to face over the coming years, projected to be a 7% increase in recruitment difficulties.

The North East is currently relatively well resourced in relation to the number of consultant posts per head of population with 11.6 per 100,000 (national range 5.4-11.6), however within NTW psychiatrists represent a lower proportion of the mental health workforce than the national average and we are currently faced with a 14% vacancy rate in consultant posts. Of significant concern we are very poorly resourced in relation to higher trainee posts (0.19 ST4 posts per 100,000, national range 0.15-0.67). We are working with colleagues in HENE to look at ways of addressing this inequity. As there is a strong association between where doctors complete their higher training and take up consultant posts this is likely to mean NTW, and the North East more widely will face particular challenges in recruiting psychiatrists in the coming years.

Our workforce strategy includes a number of elements outlined below. Points 1-6 were in place during the previous report and hence have simply been updated, additional elements new and outlined in more detail :

1. Recruitment campaign targeted at Consultant Psychiatrists and Medics in India.

First done in 2015, been repeated with trip in 2017 which during the reporting period has resulted in recruitment of five doctors, two will be working at consultant level and three at SAS level.

2. Prioritising postgraduate medical education within the trust

NTW continue to prioritise medical training and education within the trust. This is evidenced through financial support for training, medical education and training representation in key decision making committees and regular presentations to the board, growing education faculty, investment in facilities and support of trainers.

3. Retention of Consultant Psychiatrists

Over the last year we are aware that of a body of consultants we have had twenty five leave the trust, ten for retirement and fifteen for other reasons. Of those that have retired we have offered all the opportunity to return five have taken this up. Outlined below are measures in place to support retention:

- Exit interviews for all consultants to identify reasons for leaving

- Ensure medical staff are supported in their commitment to quality and safety through improved appraisal processes
- Supporting doctors in being more involved in organisational decision making, steps to achieve this include improved induction, training and the NTW consultant journey initiative
- Greater recognition of excellence and achieving organisational goals through both job planning, ACCEA and trainee awards
- Improve access to high quality medical and multidisciplinary educational opportunities through development of improved trust delivered CPD programme
- Development of a medical strategy to provide a framework to better support doctors in the career progression

4. Support for SAS doctors

The SAS doctors working within the trust are a key component of the medical workforce contributing to all aspects of trust work. As a group SAS doctors range widely in their experience and career goals. Ensuring there is appropriate support for these doctors both in their roles and, where it is wanted, to support them moving into consultant roles is an important strategy both in supporting current SAS doctors and recruiting future doctors

Over the last year we have continued to deliver a SAS CPD programme with three meetings covering confidentiality, psychopharmacology, risk assessment and MHA legislation

5. Medical Assistant role

NTW is currently piloting and evaluating this role, that although established in the US is relatively new to the UK. The role takes a different approach to some other initiatives such as physician associates which aim to have care traditionally delivered by doctors taken on by non-medical staff. The medical assistant role has at its core the aim of improving the efficiency and quality of care delivered by consultants through providing enhanced administrative and clinical support directly during clinical care. The model developed using lean principles has the advantage of retaining consultant input in more cases, improving quality and particularly suited to NTW where the proportion of consultant psychiatrists is already significantly below the average proportion of our workforce hence there is a need to ensure this resource is supported in working as efficiency as possible

This pilot has been running for 18 months and initial evaluation has been positive, demonstrating improvements in quality and efficiency there is ongoing evaluation being undertaken. We are aiming over the next year to expand the pilot to other sites.

6. Non-medical prescribing and non-medical RC roles

Development of non–medical prescribing and the non-medical RC role is already established within the trust.

Over the last year the model of clinical support units has also been developed, where teams of clinicians will work together across services to provide high level clinical input. These enhanced teams will include both medical and nurse-consultants, clinical pharmacy input and enhanced administrative support

7. SAS Fellowship programme

Over the last year we have been designing and identifying funding for a new trust run initiative for SAS doctors. This Fellowship programme is aimed at SAS doctors wanting to achieve join the specialist register through CESR. The programme includes dedicated training covering curriculum competencies as well as the opportunity to have special interest sessions in a range of specialities. Doctors on

this programme will be allocated education supervisors in a way similar to the higher training model. Our aim is to appoint to this in early 2018.

8. International medical graduate support programme

We have over the last year, following the appointment of an IMG lead developed a programme of support for IMG doctors. This includes a series of training sessions as well as access to peer and tutor support

9. Work experience

We have expanded and developed our work experience programme over the last year. We ran this programme in July and 20 students attended. From the 8 feedback responses 100% said that they will definitely be pursuing a career in medicine with 75% saying they would consider a career in psychiatry as a result of their placement. 100% would recommend a placement in psychiatry to others.
'Very positive experience. Learned a great deal about being a doctor, psychiatrist, and especially about consent and capacity'
'I had a really lovely time I learnt so much about brain injuries and Huntington's. I also really enjoyed meeting other aspiring medics'
'I now understand how vital mental health is in individuals lives. Whether that be in a neurology or a psychiatry setting, conditions of the brain/mind take over peoples wellbeing and the placement has inspired me to improve this field in my career'

The last year has continued to present considerable recruitment problems both for consultants and trainees. To some extent the impact of this has been increased by changes in locum availability hampering our ability to support services with locums to the same degree as we previously have. This is a problem that is being given high priority throughout the trust with number of different strategies in place. It is important to note that the development of additional roles is intended to enhance clinical care by working alongside consultants. We are aware our relative proportion of consultant psychiatrists is low and we aim to ensure this does not drop further and ideally grows.