JRCPTB
Joint Royal Colleges of Physicians Training Board

2015 CMT QUALITY CRITERIA TRAINING PROGRAMME DIRECTOR SURVEY RESULTS

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Royal College of Physicians of Edinburgh
Educating doctors, improving care.
ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
Royal College of Physicians

Introduction

The Core Medical Training (CMT) Quality Criteria has been developed with the purpose of driving up the quality of training environments for Core Medical Training to enhance the educational experience of trainees and ultimately to improve patient safety and experience.

The criteria have been grouped into four domains and are classified as either 'core' or 'best practice' and are expected to be met over the course of the two year programme. The four domains are:

- A - Structure of the programme
- B - Delivery and flexibility of the programme
- C - Supervision and other ongoing support available to trainees
- D - Communication with trainees

Questions relating to each of the domains have been developed and the detail of these can be found in this report.

98 respondents logged in to complete the survey, however eight abandoned the survey before completion. 86/98 (88%) of those who responded said that they were a named College Tutor or equivalent CMT lead appointed to oversee Core Medical Training at local education provider (LEP) level. The numbers of Training Programme Directors / College Tutors in each Deanery / LETB completing the survey were as follows:

Deanery / LETB	**No. who logged on**	**No. who completed the survey**	**No. of expected responses**
Defence Postgraduate Medical Deanery	0	0	
Health Education East Midlands	2	2	2
Health Education East of England	12	10	22
Health Education Kent, Surrey and Sussex	10	9	
*Health Education London (combined)	16	15	
Health Education North East	1	1	1
Health Education North West (Mersey)	8	7	10
Health Education North West (North West)	3	3	
Health Education South West (Peninsula)	7	6	5
Health Education South West (Severn)	3	2	10
Health Education Thames Valley	1	1	1
Health Education Wessex	4	4	8
Health Education West Midlands	12	12	15
Health Education Yorkshire and the Humber	8	8	14
NHS Education for Scotland	11	6	8
Northern Ireland Medical & Dental Training Agency	11	10	16
Wales Deanery	2	1	3
Total	**110**	**97**	**115**

*The trainee responses for each London LETB have been merged to provide a direct comparison with the Training Programme Director / College Tutor responses which had London as one region.

Executive Summary

Specialty Specific Questions (Quality Criteria)

- **Quality Criteria A1.** 71% of TPDs (69/97 TPDs) compared to 7% of all CMT trainees (204/2947 trainees) said the quality criteria was met by CMT trainees spending more than two thirds of time in this year of CMT contributing to the acute take.
- **Quality Criteria B1**. 60% of TPDs (58/97 TPDs) compared to 62% of all CMT trainees (1826/2947 trainees) strongly agreed or agreed that shift patterns allowed CMTs to easily attend relevant post-take ward rounds and handovers.
- **Quality Criteria B2.** 10% of TPDs (10/97 TPDs) compared to 16% of all CMT trainees (476/2947 trainees) expected CMTs to meet the quality criteria by attending 20 or more outpatient clinics this year.
- **Quality Criteria B3.** 39% of TPDs (38/97 TPDs) compared to 15% of all CMT trainees (448/2947 trainees) strongly agreed or agreed that CMTs normally have protected learning time, for example at PACES training or outpatient clinics, where their attendance is bleep - free.
- **Quality Criteria B4.1** 90% of TPDs (87/97 TPDs) compared to 63% of all CMT trainees (1869/2947 trainees) agreed CMTs have had the opportunity to attend skills laboratory or simulation training (using scenarios) at least once a year.
- **Quality Criteria B4.2** 66% of TPDs (64/97 TPDs) compared to 34% of all CMT trainees (1010/2947 trainees) strongly agreed or agreed that when CMTs were undertaking scenario simulation training, training included all mandatory procedural skills. 40% of CT1 and 33% of CT2 trainees said this was not applicable to their training.
- **Quality Criteria B5.1** 90% of TPDs (87/97 TPDs) compared to 62% of all CMT trainees (1831/2947 trainees) agreed CMTs normally receive a minimum of one hour curriculum-relevant teaching on average a week.
- **Quality Criteria B5.2** 73% of TPDs (71/97 TPDs) compared to 35% of all CMT trainees (1021/2947 trainees) agreed that in the post CMTs had at the time of completing the survey, they had regular teaching, including direct observation of clinical skills, relevant to passing PACES.
- **Quality Criteria C1**. 65% of TPDs (63/97 TPDs) compared to 56% of all CMT trainees (1660/2947 trainees) agreed that in their current Trust, CMT trainees are normally represented on appropriate professional or education committees.
- **Quality Criteria C2**. 92% of TPDs (89/97 TPDs) compared to 59% of all CMT trainees (1759/2947 trainees) agreed that CMTs had the opportunity to attend a department introduction to the system of training assessment and review within one month of starting the CMT programme.
- **Quality Criteria C3.** 93% of TPDs (90/97 TPDs) compared to 87% of all CMT trainees (2555/2947 trainees) agreed that their current Trust has a named senior member of staff or College Tutor appointed to oversee CMT training.
- **Quality Criteria C4.1** 81% of TPDs (79/97 TPDs) agreed that each trainee has a single, named Educational Supervisor appointed to oversee their CMT training for a minimum of 12 months.
- **Quality Criteria C4.2** 69% of TPDs (67/97 TPDs) agreed that all Educational Supervisors have been selected, trained and assessed as per national guidance.
- **Quality Criteria C4.3** 28% of TPDs (27/97 TPDs) agreed that on average, Educational Supervisors have allocated 0.25PAs or more per trainee specifically for supervision duties.

- **Quality Criteria C5.** 87% of TPDs (84/97 TPDs) compared to 71% of all CMT trainees (2105/2947 trainees) agreed that CMTs had had, or will have, a formal interim review (also known as a 'pre-ARCP appraisal') before their ARCP.
- **Quality Criteria C6.1** 27% of TPDs (26/97 TPDs) compared to 55% of all CMT trainees (1622/2947 trainees) said that CMTs have agreed, or will agree, a plan for MRCP(UK) training with their Educational Supervisor before attempting the examinations.
- **Quality Criteria C6.2** 36% of TPDs (35/97 TPDs) agreed that all trainees identified as requiring more support with examinations receive enhanced training and / or supervision.
- **Quality Criteria D1.** 66% of TPDs (64/97 TPDs) compared to 66% of all CMT trainees (1935/2947 trainees) agreed or strongly agreed that at the time of their job offer, CMTs were given enough information about the possible rotations within the CMT programme. **This compares to 68% of CMT trainees in the 2014 survey.**
- **Quality Criteria D2.1** 42% of TPDs (41/97 TPDs) compared to 51% of all CMT trainees (1505/2947 trainees) said that CMTs were given at least six weeks' notice of their on-call rotas.
- **Quality Criteria D2.2** 97% of TPDs (94/97 TPDs) compared to 93% of all CMT trainees (2739/2947 trainees) said that CMTs on-call rota covered more than three months in length.

Deaneries / LETBs have been listed alphabetically by quartile in the table below with 'quartile four' containing the highest ranked and 'quartile one' the lowest. The data was produced by taking an average of all quality criteria percentages **with the exception of C4.1, C4.2, C4.3, and C6.2 as trainees were not asked these questions**. This allows for a direct comparison between TPD and trainee surveys.

( ) indicates the quartile in which the deanery / LETB was placed when trainees were asked the same questions in the GMC Trainee Survey.

Quartile	Deanery / LETB	N=	A1	B1	B2	B3	B4.1	B4.2	B5.1	B5.2	C1	C2	C3	C4.1	C4.2	C4.3	C5	C6.1	C6.2	D1	D2.1	D2.2
4	Health Education Kent, Surrey	9	100	44	11	22	89	78	100	100	100	89	100	100	100	11	100	44	11	89	56	66
(4)	and Sussex	161	7	60	12	9	70	76	73	43	79	72	100				91	68		58	37	99
4	Health Education London	16	50	73	21	40	100	93	93	93	80	100	100	87	80	40	93	27	47	60	67	93
(3)	(LETBs combined)	540	7	66	19	19	86	57	59	35	65	67	99				84	70		59	43	88
4	Health Education Wessex	4	100	100	0	50	100	75	75	100	25	100	100	100	100	25	75	75	75	100	0	100
(1)		109	2	74	12	0	30	27	41	27	56	67	100				62	67		80	70	99
4	Health Education Yorkshire and	8	75	63	0	75	87	100	100	87	75	87	100	100	50	38	87	50	25	83	13	100
(3)	the Humber	289	9	61	10	15	76	50	65	33	50	64	99				73	67		74	67	97
3	Health Education East Midlands	2	100	50	50	50	100	100	50	50	100	100	100	100	100	0	50	0	50	50	50	100
(1)		148	10	66	11	21	63	47	60	38	51	61	100				21	62		79	31	97
4	Health Education East	11	55	70	11	80	90	70	100	70	70	90	100	90	80	40	60	40	40	100	30	100
(2)	of England	229	5	64	5	17	82	47	74	45	67	57	100				40	66		66	60	97
3	Health Education South West	2	50	50	0	50	100	100	50	50	50	100	100	100	100	0	100	50	50	50	50	100
(1)	(Severn)	111	2	66	8	17	66	46	88	46	73	61	100				74	70		53	48	96
3	Health Education West	12	67	67	8	42	100	100	100	67	50	92	100	100	75	25	92	8	42	42	25	100
(2)	Midlands	211	9	68	42	20	39	39	76	49	46	75	95				65	67		50	54	97
2	Health Education NW (Mersey)	7	86	57	17	29	100	71	86	71	43	71	100	17	29	43	100	14	29	67	29	43
(2)		141	6	55	17	13	59	50	57	32	49	67	98				61	55		71	49	89
2	Health Education NW (North	3	33	33	0	33	100	100	100	100	33	67	100	33	100	0	66	33	33	67	66	100
(3)	West)	175	6	53	11	15	71	73	64	31	49	69	99				94	68		78	51	88
2	Health Education South West	7	71	50	0	17	67	50	83	50	50	100	100	100	83	33	100	17	17	83	83	100
(4)	(Peninsula)	81	7	61	4	11	56	34	59	32	66	60	99				58	72		56	48	97
2	Health Education Thames	1	100	100	100	0	0	100	100	100	25	100	100	100	100	100	0	100	100	0	0	100
(3)	Valley	74	5	86	26	17	32	22	84	42	85	74	94				77	69		72	57	95
2	Wales Deanery	2	100	100	0	0	100	100	100	0	0	100	100	100	100	100	100	0	0	100	0	100
(3)		204	8	71	17	14	46	65	59	44	53	49	100				77	80		79	70	99
1	Defence Postgraduate Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
(4)	Deanery	4	25	67	50	50	75	50	100	50	25	50	100				75	50		100	75	100
1	Health Education North East	1	0	0	0	0	100	100	100	100	100	100	100	100	0	0	100	0	100	0	100	0
(4)		132	5	70	9	13	46	64	78	45	62	73	98				99	78		61	50	90
1	NHS Education for Scotland	6	50	50	0	17	100	66	83	83	67	100	40	67	33	33	67	0	67	67	50	50
(1)		214	5	49	24	10	73	55	23	26	55	63	99				85	60		53	32	87
1	Northern Ireland Medical &	10	100	40	10	20	60	30	70	20	60	90	100	44	22	0	100	10	10	50	40	90
(2)	Dental Training Agency	124	11	70	32	21	47	44	60	34	58	81	100				65	61		71	58	97

Deaneries/LETBs in alphabetical order by quartile. Indicators C4.1, C4.2, C4.3 and C6.2 have not been included as trainees were not asked these questions.

Quality Criteria A.1 Minimum of two-thirds of placements (usually 16 months) spent contributing to the acute medical take, including the acute medical unit.

Q. On average per two year programme, what proportion of placements contribute to the acute medical take?

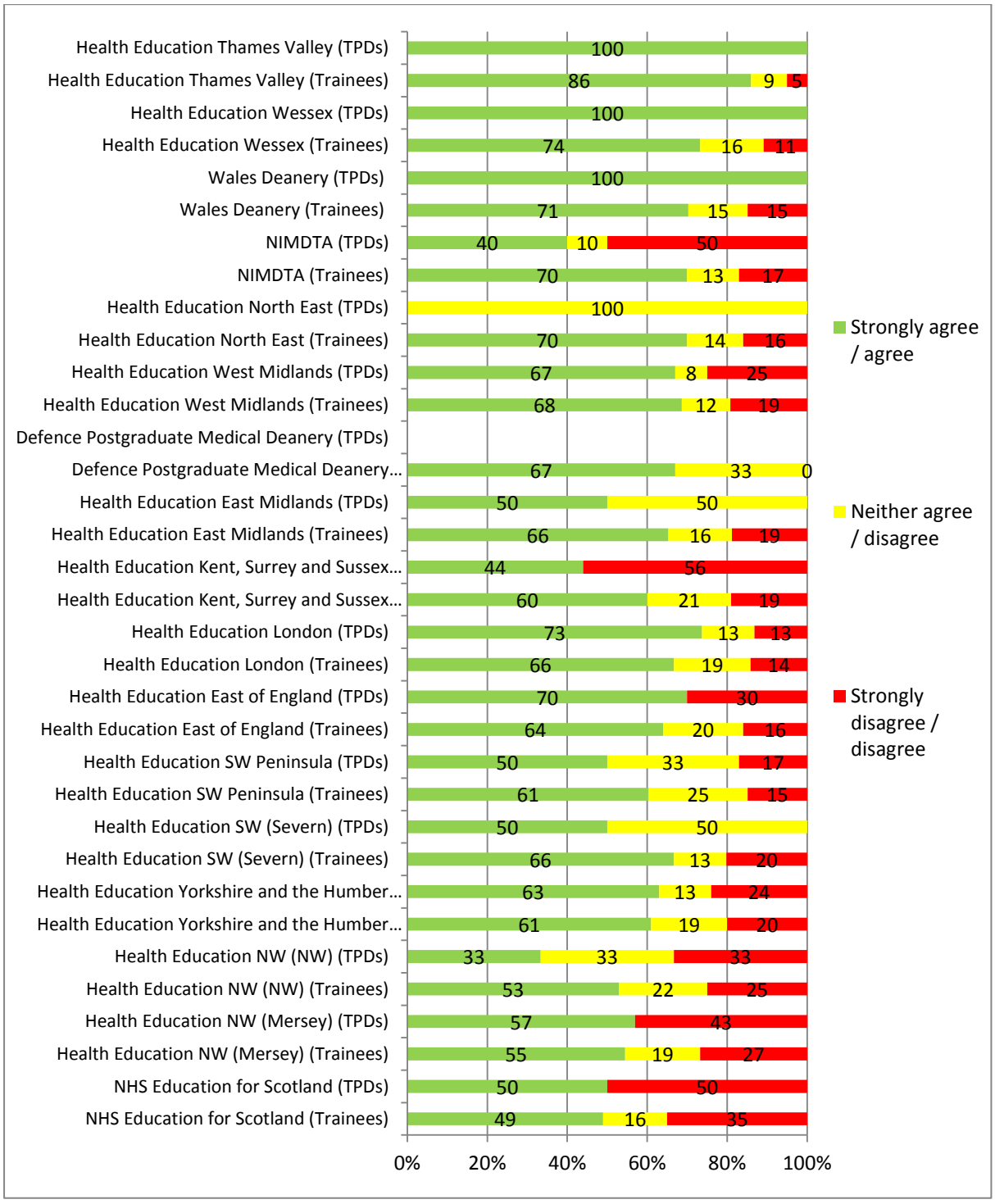
A1. 67% of TPDs (51/76 TPDs) compared to 7% of all CMT trainees (204/2947 trainees) said the quality criteria was met by CMT trainees spending more than two thirds of time in this year of CMT contributing to the acute take.

A1. Training Programme Director / College Tutor comments (25)

- 100%
- 12 months minimum
- 2/3, I would not accept less than this but as we are a tertiary centre they get renal and neurology which is great, but they then do specialty take.
- All the rotations in my Trust fulfill this condition
- All the specialties in the rotation are part of acute take including oncology
- During the year they are attached at HDH. Not sure about contribution for the rest of the year.
- Each trainee does a mandatory 4 month period on the medical assessment unit in addition to on calls during some attachments.
- Exposure to specialty take at Nottingham City. This is being looked at to allow better exposure to acute medicine.
- In the 1 year that trainees spend in my organisation 6 out of 11 posts have a 4 month rotation in AMU and all of the others will spend blocks of time (including nights) based on AMU
- In this zone it is 100%
- It is on average 3 placements, but can be varied. I have tried to even it out for the coming year.
- It varies across the CMT rotations from 12 months in 1 of the 2 year rotations to 18 months in another
- New rota in place to achieve this
- OOH and acute medical take work rota runs parallel to placement ward work.
- Posts such as ITU, haematology and oncology have a separate rota. All other posts have unselected medical on call
- Rotations have a 4 month attachment to the Acute Assessment Unit.
- Some of the posts are 4 month blocks in acute medicine when they do 'on call' work for the whole 4 months and we feel should get increased recognition beyond 4 months of contributing to acute take.
- The CMT form the backbone of the acute medical take in a DGH
- Most of the curriculum competencies and training up to become a ST3 happen while on call
- The contribution to take is important but needs to be balanced with the training and learning opportunity in that contribution.
- There should be consideration given to specialties such as Renal Medicine which provide excellent experience in general medicine although it is not labeled as such. Renal experience should definitely be considered under the umbrella of acute medical experience .
- Trainees have 4 month blocks of AMU where they contribute to the acute take. For the rest if the time they contribute to acute take within their specialty. Those who go to DGHs contribute to acute take for that entire year.
- We have 16 trainees and 2 posts (each of 4 months) at any one time are acute medicine= 2/16 = 12%
- We in Queen Elizabeth Hospital Birmingham have multiple specialty wards due to the tertiary nature of the hospital. Specialty medical teams have their own takes where the CMTs contribute. This involves both very specialty specific experience and management.
- Year 2 trainees have placements on AAU

Quality Criteria B.1 Shift patterns to be structured to ensure trainee attendance at relevant post-take ward rounds and handovers.

Q. My shift patterns allow me to easily attend relevant post-take ward rounds and handovers.



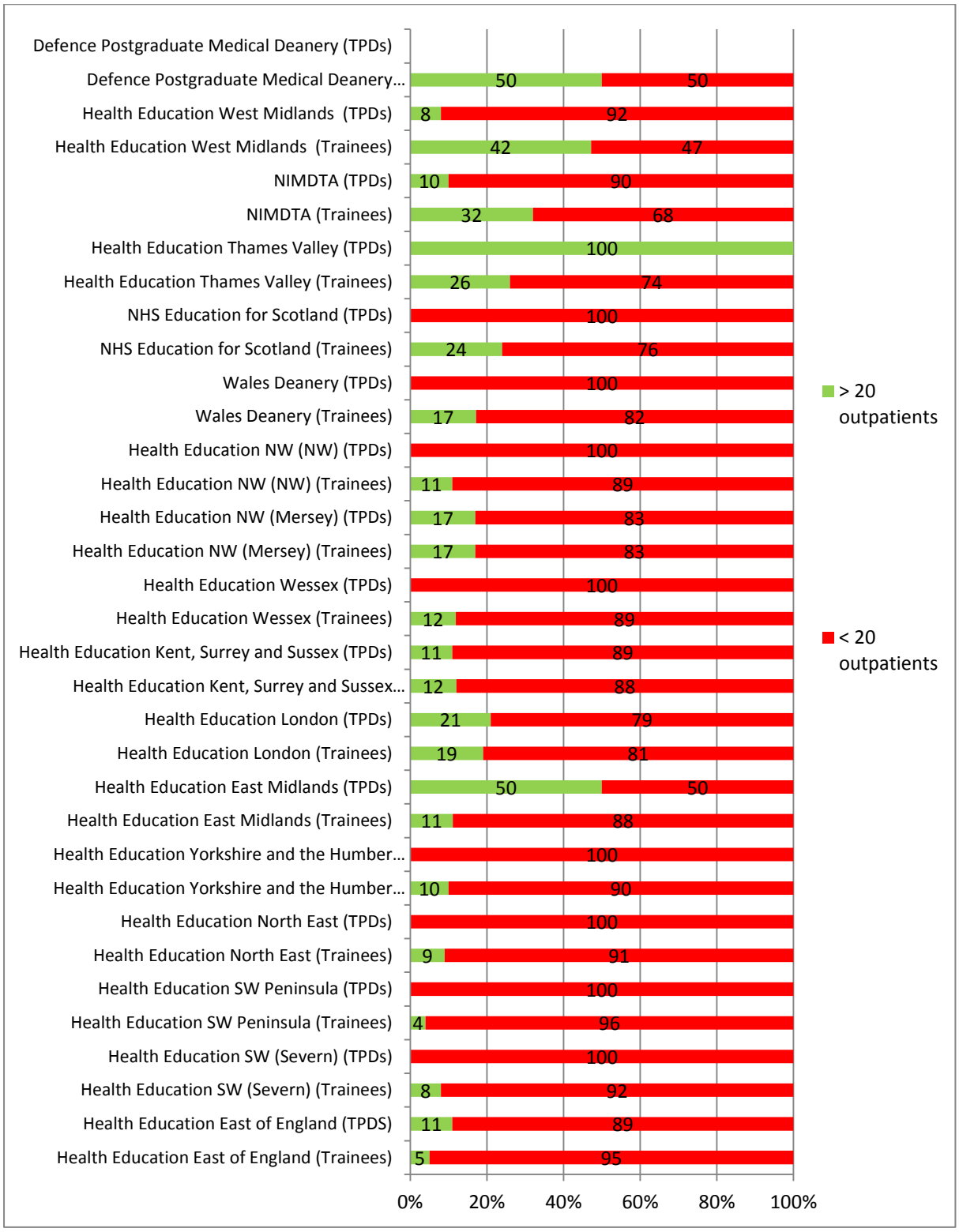
- **B1**. 65% of TPDs (47/72 TPDs) compared to 62% of all CMT trainees (1826/2947 trainees) strongly agreed or agreed that shift patterns allowed CMTs to easily attend relevant post-take ward rounds and handovers.

B1. Training Programme Director / College Tutor comments (22)

- Week block of acute take which factors this in
- Two handovers per 24 hours One full post-take WR (pm) and One part Post-take WR (am. due to handover and EWTD pattern)
- No formal post take ward rounds available in my Trust - this is something me and the other tutor here know is a problem and we are looking at ways to improve things.
- PTWR starts at 07:30-08:00 which gives the trainees on nights 1-1.5 hous to present the patients they have seen and undertake ACATs. The trainees are not always proactive in taking up this opportunity. All handovers are timed to be aligned to shift rotations. There is Consultant presence (mon-fri) until 21:30 so trainees can present their cases to the Consultant; again many are not proactive in taking up this opporunity.
- We are in the process of developing a better morning handover procedure which will allow greater involvement of the night shift.
- But extreemely difficult to deliver as a TPD
- There are 3 hospitals in my trust but I can only comment for my hospital
- Should be easy to attend hand overs and get feedback within this (a board round rather than a handover). Also usually the opportunity to see a couple of sick/interesting patients, but cannot attend full post take ward round due to shift patterns
- Works well in some place but not others. i think this reflects the level of medical leadership, the recognition of need for training and the pressures from management
- 2 acute physician consultants daily to ensure, consultant post take review and timely finish to shifts
- Post take morning ward rounds often continue to the extent that they make the overnight shift last too long or the doctor has to leave on time before all their clerked patients have been reviewed.
- Strongly agree for hand overs here but not for post take ward rounds. POst take is an issue the morning after here our acute physicians need to operate at 8am start to facilitate post take am experience and this is not yet in place here although working towards. In daytime however they can get post take experience so part way satisfied up until 9pm at night
- Trainees are able to attend handover regularly. However, post take ward rounds are not necessarily attended by trainees who have been involved with the care of the patients seen on the ward round.
- Speciality shifts are set up around post take ward rounds and handover. AMU is more difficult but registrar rotas are set up to allow attendence on post take ward rounds.
- I’m aware that the system of handover between night and day times at UHB is not as good as it should be for trainees, I will be working to solve this over the next few months
- Day admissions reviewed within 4 hours by Consultants and feedback offered, night -take patients reviewed by Consultant from 8 am until 9.15 am due to worktime restrictions.
- Because of hours constraints trainees may need to leave before be able to present patients
- Handover has been reorganised several times to be more functional
- Handover proceses have improved with shift redesign but day shift on call does not necessarily allow for Posttake review. AMU consultant dependant in Week, weekend plan better perhaps in this respect
- NO
- There is regular hand over meeting after each shift but juniors usually dont stay for post-take ward round due to europeon time restriction ,in our hospital take divided between 4 consultants so paitents clarked by them may not be the ones seen by consultnant with whom CT is going around .
- Varies by post

Quality Criteria B.2 Minimum of 40 outpatient clinics over the course of the programme.

Q. How many outpatients' clinics do you expect to attend this year?



B2. 11% of TPDs (8/72 TPDs) compared to 16% of all CMT trainees (476/2947 trainees) expected CMTs to meet the quality criteria by attending 20 or more outpatient clinics this year.

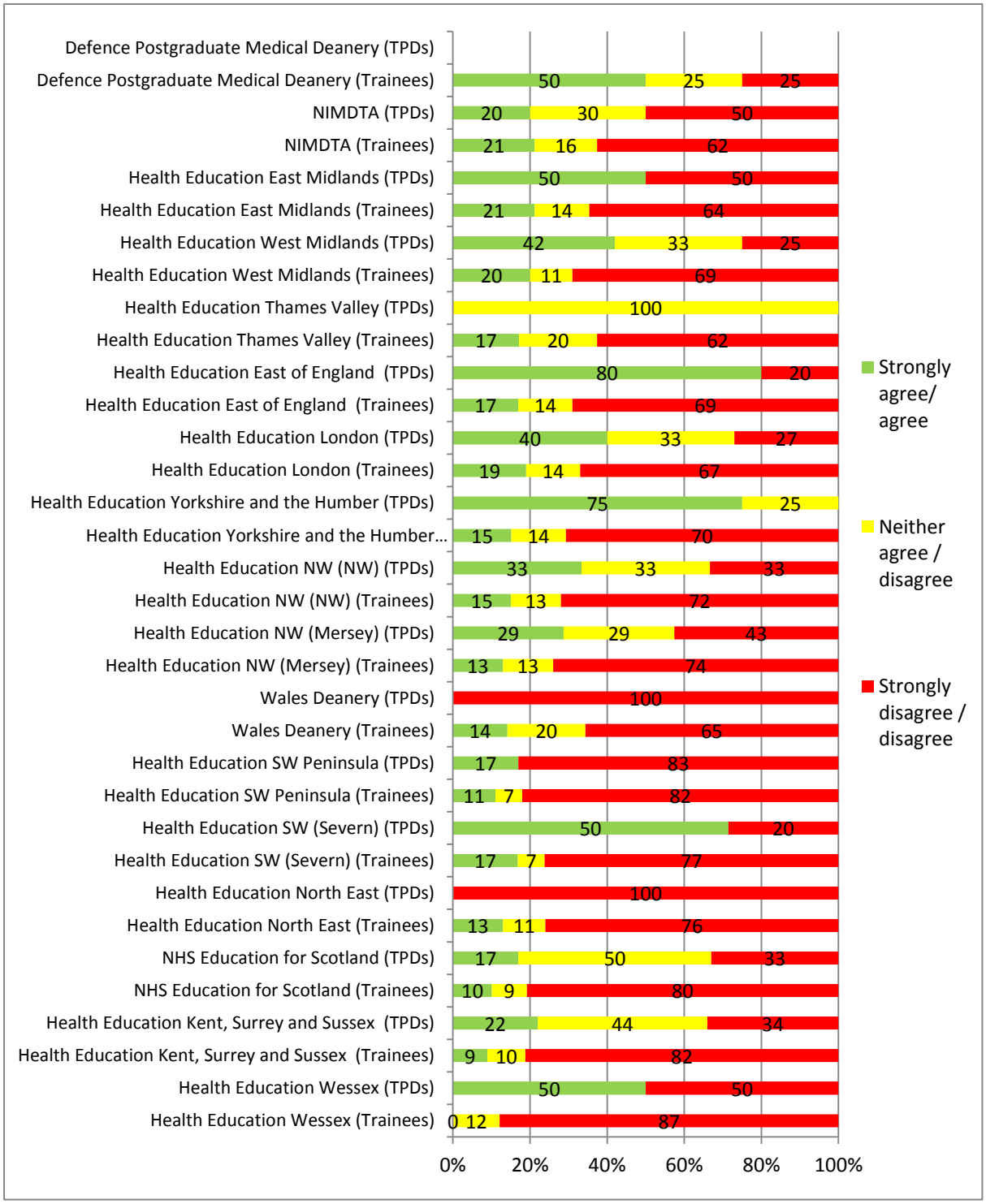
B2. Training Programme Director / College Tutor comments (44)

- We are aiming for all trainees to achieve the 40 metric
- This needs dedicated time allowed bleep free to attend otherwise this is unachievable
- In one year, we have trainees only for one year
- During the year at HDH they are encouraged to attend 12 through the year.
- This is probably a greatest challenge of all to achieve unless the LEPs are given an incentive e.g. more number of CMTs for example
- I can only comment on a one year cycle.
- I only have a small number of trainees for 1 year. We have struggled to get them appropriate levels of outpatient experience because of inpatient ward commitments. We are taking steps to resolve this from August and aim to achieve at least 20 clinics in 1 year.
- We believe the opportunities for all trainees to attend in excess of 40 clinics/2 years but many are slow to take these opportunities. Therefore, in the future we will be rostering clinics for CMTs to guarantee attendance.
- Most trainees are able to attend 24 clinics because they are expected to. They would like to attend more but CMT trainees are end up being the only doctor that can deliver the service as foundation doctors head off to their compulsory training and registrars head to clinics or their training.
- Difficulty of finding clinic space is a problem
- Aim for 24 we will try to get to 40 soon - if the ARCP decision aid said 40 we would be able to enforce it.....
- Trusts need to acknowledge this and provide enough clinic space for trainees to attend clinics
- Varies by trainee but this is achieved in 80% of my trainees
- We are planning to implement bleep free compulsory clinics
- Getting to clinics is an area trainees struggle with. Perceived pressure to be on ward. Trying to address by making sure trainees are timetabled to attend clinics and engaging supervisors to facilitate clinic attendance.
- Very variable according to placement. We aim for one clinic per week. Some post have a clinic block.
- 20 clinics per 2 year programme is appropriate. It is important this is looked at over the 2 years and not per year to allow posts that may not have clinics eg ITU to be incorporated. It will be very challenging to deliver 40 clinics. We want trainees to do plenty of acute medicine which is often best delivered by a shift system - trainees cannot do clinics during days on take, on nights, on time off after nights, during study or annual leave.
- This will be the most challenging of the core criteria to meet. It should also be recognised that a trainee may have just as important learning experience from "sitting in" on a highly specialised clinic and not actually seeing patients themselves, though this should be balanced with doing more general clinics that they see patients for themselves. These are equally valuable learning opportunities, and if specialty clinics are not valid unless they have their "own list", trainees will miss out on a potentially very valuable learning opportunity.
- We are planning to map all available clinics to make them available to all trainees including the ones who are not posted to that specialty.
- It is very hard work for them to achieve the forty but they do as it is the only way to pass arcp (which is appropriate)
- 40 would be aspirational
- We mandate 24 clinics in 2 years currently, and they struggle to achieve this.
- With great difficulty. 1. Ward workload and staffing resources 2. A reluctance to leave their FY colleague's alone on the ward 3. serious lack of clinic rooms

- It is difficult to timetable a clinic for a trainee as they have wards duties. They may be offered a clinic to come to, but feel they have to be on the ward if a patient is ill. Therefore they don't get allocated patients to see, which takes away the pressure for them to attend (and therefore the excuse not to be on the ward). Then there is the difficulty finding space for them to see patients as clinic rooms are in high demand. I think it will be extremely difficult for them to reach the new target of 40
- Allocating clinic to CMT extremely difficult due to rota changes
- Limited capacity and availability of clinics.
- Whilst at Hinchingbrooke they have a clinic week each 6 months; some CMTs are here for 1 year and others 6 months.
- There will need to be a step change of approach to get trainees to clinic at these rates.
- This standard has only recently been applied our trainees were getting 24 clinics per year this far this year will be first time we are attempting to achieve this 20 per year target. We feel we can do it
- Based on average of last batch of CMT trainees.
- Majority of trainees struggle a little to get to 12 clinics per year
- This will be very challenging to achieve
- Varies between posts - Lots in some posts 3 or 4 per week. to occasional in other posts
- There should be a requirement to see a minimum number of patients in each clinic as many would just see one patient in a clinic.
- Ensuring that this means: 1) a clinic where THEY see the patient (ie. not sitting in) 2) see multiple patients (ie. NOT one patient per clinic as (a few) trainees try and 'game' things is the challenge (for me) 3)A clinic is sufficiently general (ie. not super-super specialised)
- Our CMTs struggle to attend the present minimum of 1 clinic per month due to various reasons- no surplus junior workforce to allow protected clinic time, busy wards and takes, lack of clinic space and often, self-organisation wanting
- Very difficult unless timetabled in and consultants actively encourage them to go
- Varies a lot depending which job. But all trainees achieved sufficient clinics for sign off at ARCP
- Intention to improve but rota demands, and lack of outpatient space/resources and ward support limits attendance
- In my hospital for 6 months they all get clinics but cannot comment on the other 18 months
- Depends which specialty they are and which hospital, eg if in rheumatology / or cardiology in my hospital they have plenty of opportunity but not in other specialties
- Trainees must complete the minimum required on ARCP decision aid. Focus has been on documenting minimum requirement of 24 - this has been challenging for some postings New log-book may make it easier to determine 'average'
- The increasing clinical workload and inadequate number of CMT equivalent staff mean that it is difficult for some trainees to attend clinics whilst also maintaining safe levels of ward cover. Furthermore, inadequate outpatient infrastructure means that often there are not enough clinic rooms to allow CMT doctors to see patients separately in clinic rooms alongside the supervising consultant
- This has been a struggle – meeting 24 per year

Quality Criteria B.3 Bleep-free cover arrangements to facilitate attendance at outpatient clinics and other learning events, e.g. PACES training, as protected learning time.

Q. I normally have protected learning time, for example at PACES training or outpatient clinics, where my attendance is bleep -free.



B3. 46% of TPDs (33/72 TPDs) compared to 15% of all CMT trainees (448/2947 trainees) strongly agreed or agreed that CMTs normally have protected learning time, for example at PACES training or outpatient clinics, where their attendance is bleep -free.

B3. Training Programme Director / College Tutor comments (32)

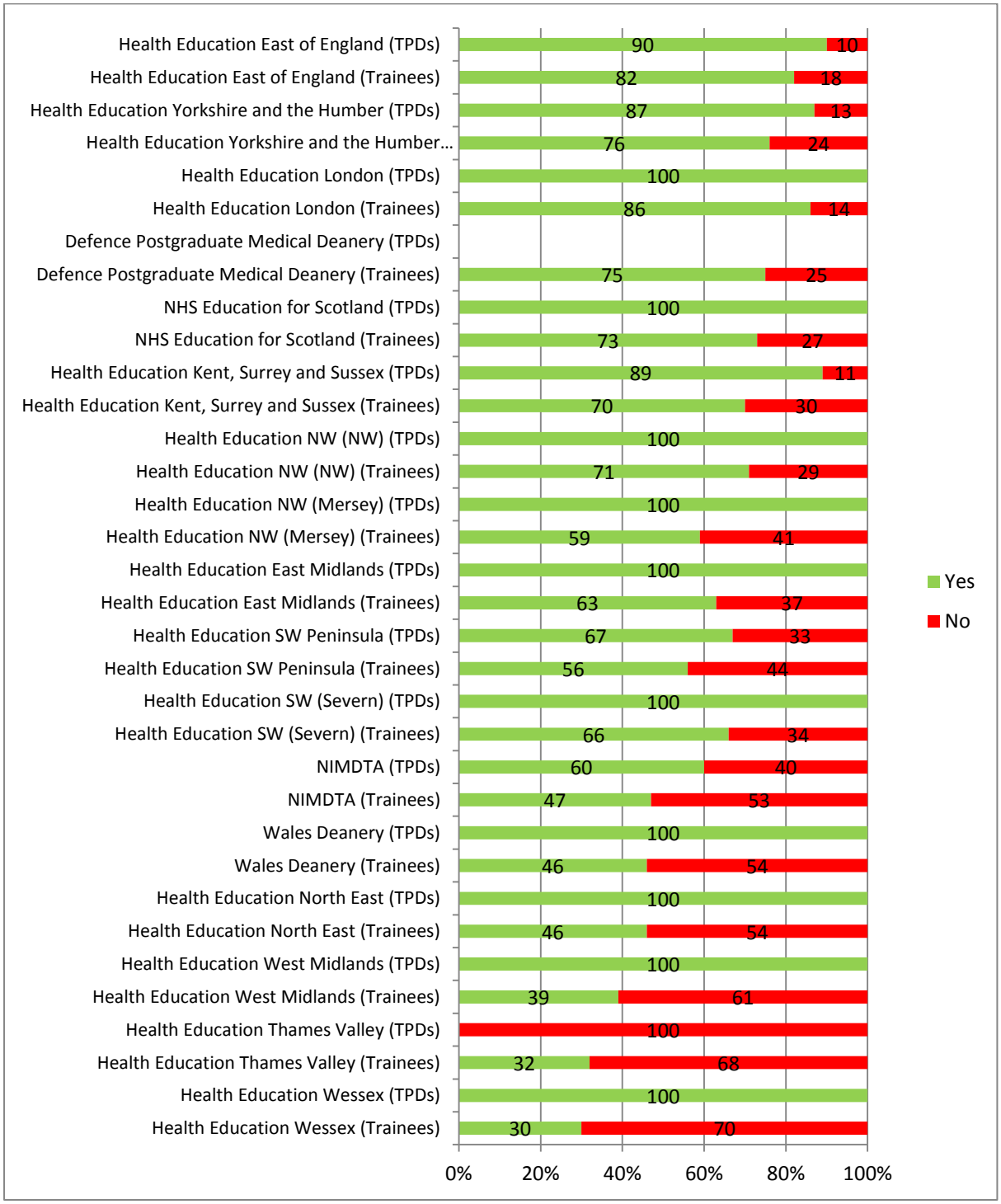
- Bleep free for PACES and other in-house 3 weekly education sessions. Not bleep free during out-patients, as other medical staff.
- No Brainer
- Trainees normally carry their bleep during the teaching
- Teaching sessions are bleep free. Bleep free clinic attendances bleep free is achievable provided trainees take some responsibilty for arranging cross cover within themselves.
- Often difficult for the trainees to get to these teachings because of the pressure in the wards
- This has been encouraged but not enforced - it will be looked at again with trainees.
- Until now trainees have usually carried bleeps with them to clinic we will be changing this so that clinics are treated like rostered leave or on call work.
- We are aiming to implement this from August
- PACES training and clinic attendance occurs, but is not routinely bleep free currently.
- Teams already very limited so often no one will hold the bleep, and no one wants to ask! We can try to enforce this.
- Teaching bleep free but not clinics
- While trainees may not be entirely bleep free at clinics - for instance may answer phone queries wards are aware that they are not available acutely. This scenario represents real life. They are bleep free for PACEs teaching etc
- Protected learning time is important. Study leave is bleep free. However protected in house delivered teaching will depend on the availability of other staff and other trainees as patient care is paramount.
- Agree that attendance to protected teaching time including PACES should be bleep free, but not the clinics.
- We try to enforce bleep free teaching. there is always the question of patient safety. further, other trainees have teaching on the same day making cover difficult
- We do not have the cover available on the wards to provide this routinely; the one hour CMT teaching weekly is bleep free.
- CMT teaching is bleep free, PACES teaching is out of hours. However it is not possible to make attendance at Outpatient bleep free as they are the only doctor on the ward sometimes. The registrarrs are not bleep free either. This is an aspiration which is not feasible in a busy hospital environment.
- Ensuring bleep free difficult
- The clinic weeks should be bleep free. CMT teaching should also be bleep free but the wards do not always respect this
- Trainees need to organise the time to make sure ward work is done as well.
- We make teaching bleep free already this is for local CMT sessions and PACES clinics are not yet bleep free and this is going to be very challenging to achieve due to spare ward cover
- Trainees have bleep free protected weekly teaching, but not bleep free protected outpatient clinics.
- Ideally would be bleep free, but consultants are not bleep free in clinics & CMTs will need to field calls as part of their training.
- PACES training should be out of hours and trainees need to be available for ward advice when in clinic
- Question has too many threads. Protected teaching yes - Bleep free Outpatients not bleep free but time is protected and timetabled in most posts - working on the others to get them timetables
- Agree, although I would query re 'bleep free' as these are adults and they should: 1)be able to manage their time (ie be able to take SOME calls during clinic (as that is what will happen

when they are a Consultant!) 2)be able to speak to colleagues to ensure that their patients are covered

- They may have to handover the bleep to a colleague but this may not be always possible due to absences.
- Again, difficult with work pressures
- Insufficient staff to facilitate bleep cover and Not sufficient LEP staff to facilitate either. Sometines firm may consist of 2 doctors, Fy1 and CMT so FY1 needs to be able to gain advice in medical emergency from CMT when registrar not available
- Unfortunately excessive service comittment does not allow this
- Would be bleep free with us in clinics, and as our PACES teaching would be on-site, and predominantly outside 9-5, would be bleep free. Cannot say outside of my DGH hospital.
- Bleep free education sessions (2 hours per week) but not bleep free PACES training or outpatient clinics.

B.4 Skills laboratory and / or simulation training (using scenarios) for all mandatory procedural skills to be provided at least once a year to supplement clinical training

Q. In this CMT programme, I have had the opportunity to attend skills laboratory or simulation training (using scenarios) at least once a year.



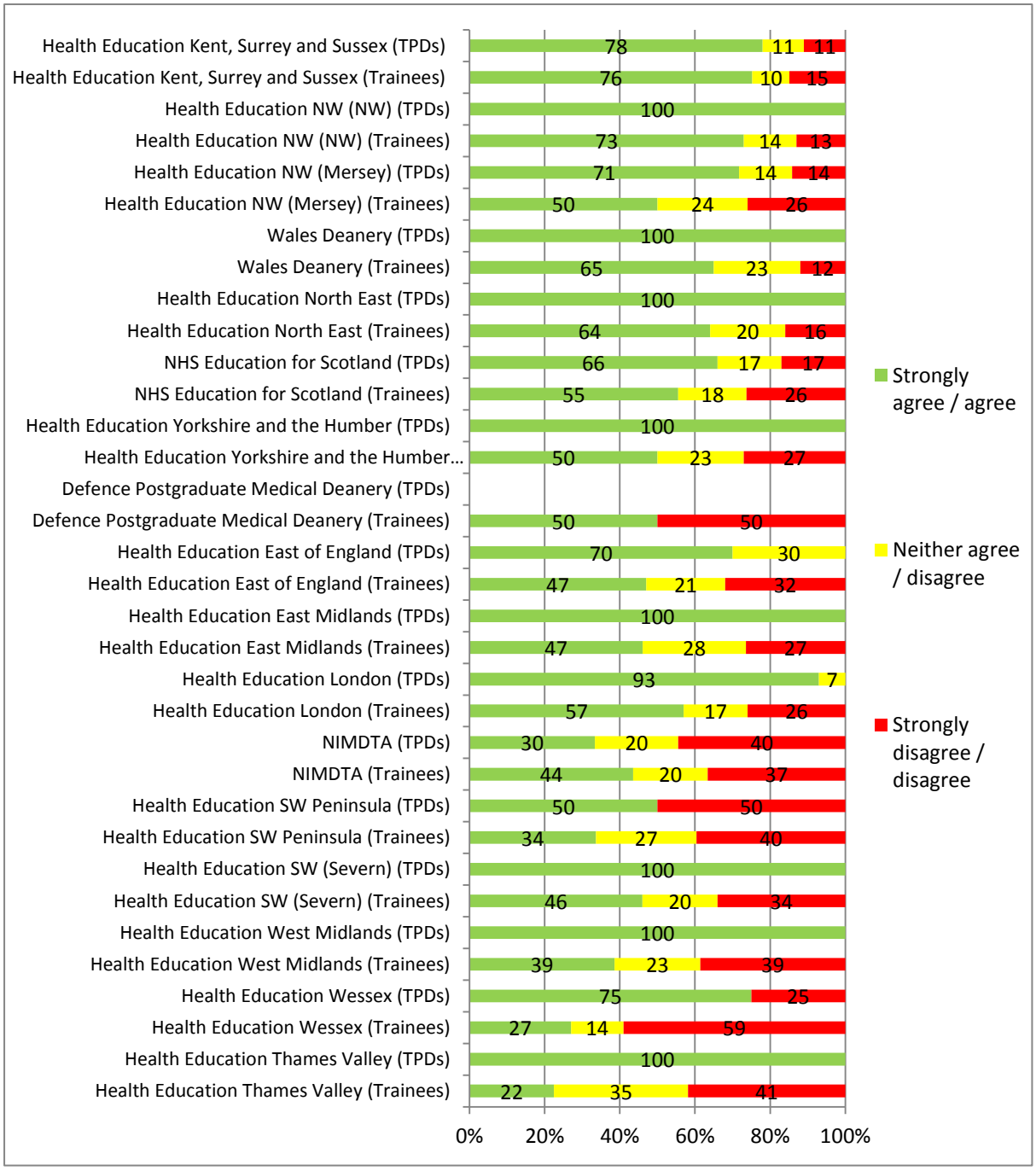
B4.1 93% of TPDs (67/72 TPDs) compared to 63% of all CMT trainees (1869/2947 trainees) agreed CMTs have had the opportunity to attend skills laboratory or simulation training (using scenarios) at least once a year.

B4.1 Training Programme Director / College Tutor comments (20)

- Attend once in two years a regional scenarios simulation Generic Teaching day. From August 2015 we are planning to deliver both procedural and scenario simulation anuualy at locality
- Organised at Hull.
- Only started this year at RSH
- Both in both years. I am very dissapointed by the standards document being so weak on this. I thought the RCP was supposed to set high standards not sink to the lowest common denominator.
- Local RCP course open to all trainees and from Aug 2016 will expcet all trainees to attend.
- Active multiprofessional training programs using simulation on site throughout the year
- Unclear of the value of repeating all skills laboratory training in CT1 and CT2. Central lines and chest drains are worth repeating if no opportunity to do in clinical situation. However simulation training with scenarios very avlauble in both years
- Established in north; rolling out in the south
- Regional provision
- It is available, but not usually anually.
- Not on our site but can arrange themselves.
- Specific procedure days arranged
- But not all attend. Should be mandatory.
- Trainess are encouraged to attend regional skills and simulation training courses.
- Local US guided procedure course run once a year.many more around the region. Local simulation sessions (4 with 3 CMTs per session to happen from the 7th of Decemebr).Most CMTs make avail of the Deanery funded Simulation day.
- There is an opportunity with limited spaces arranged by the deanery but very inadequate numbers and not all trainees can get to it due to service commitments
- Generally they get there
- Once in 2 years currently but also Sim cases sessions may enable some additional procedures supervsion
- Encouraged to attend IMPACT. Local simulation lab in development.
- We are working at a Deanery level to implement this over next 12-24 months.

B4.2 Skills laboratory and / or simulation training (using scenarios) for all mandatory procedural skills to be provided at least once a year to supplement clinical training.

Q. When undertaking scenario simulation training, the training includes all mandatory procedural skills.



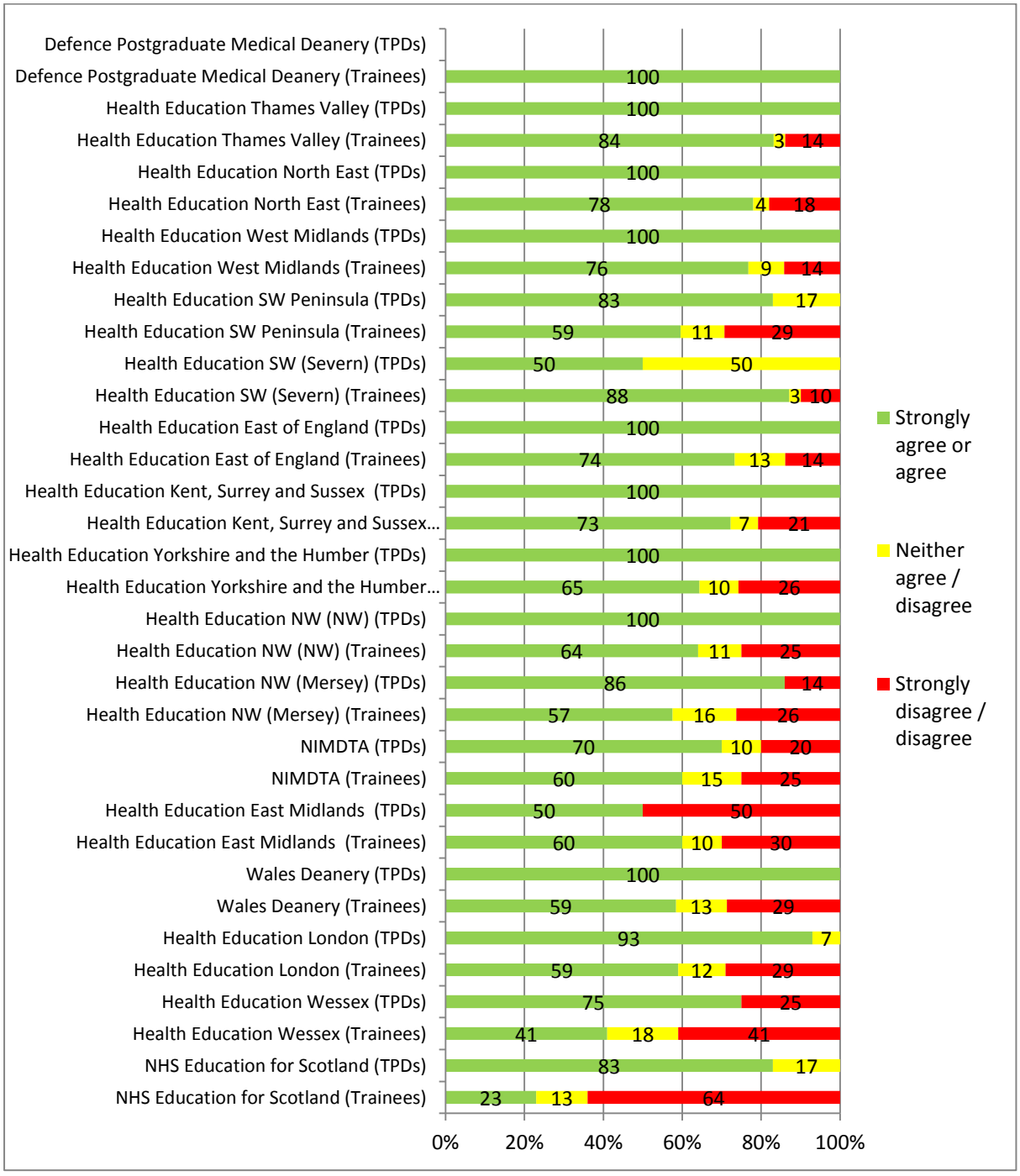
B4.2 69% of TPDs (50/72 TPDs) compared to 34% of all CMT trainees (1010/2947 trainees) strongly agreed or agreed that when CMTs were undertaking scenario simulation training, training included all mandatory procedural skills. 40% of CT1 and 33% of CT2 trainees said this was not applicable to their training.

B4.2 Training Programme Director / College Tutor comments (15)

- Include majority but not all procedures. LP and chest drain will be introduced August 2015
- We have an excellent procedure skills course
- We are developing this programme and have previously focused on chest drains.
- This is to start in Winter 2015
- All curriculum practical skills are taught to all CMTs shortly after induction in the sim lab. this has been the case for the last 3 years
- Trainees should all have opportunity to practice these skills prior to procedures being performed with the patient.
- This has now been funded by HENCEL for 3 years in a row, and although not mandated, all trainees are given the opportunity to attend with a gentleman's agreement to attend any other centre in UCLP to find a date which suits their timetable.
- Chest drain insertion, central line and we are introducing LP training
- In the north there is a ct1 and ct2 session; being rolled out across the north
- Does not include ascetic tap & NGT. concentrates on LP. central lines and chest drain.
- Chest drain, CVP and LP
- Clinical skills courses are provided regionally.
- We have arranged procedural skills lab training for chest drain insertion and CVC in our Trust. We are also doing three high fidelity simulation training days for CMTs. I think the procedural training opportunities if available in a Trust should be allowed to make mandatory. Not all Trusts will have the resources to provide this but in our region we have offered other Trusts places for their trainees to our courses.
- Ultrasound guided procedures not perhaps covered as well as might.
- It is difficult to accurately reproduce all the mandatory procedural skills in a SIM environment.

B5.1 A minimum of one hour curriculum-relevant teaching per week on average, to include a regular rolling programme of direct observation of clinical skills around the PACES diet.

Q. I normally receive a minimum of one hour curriculum-relevant teaching on average a week.



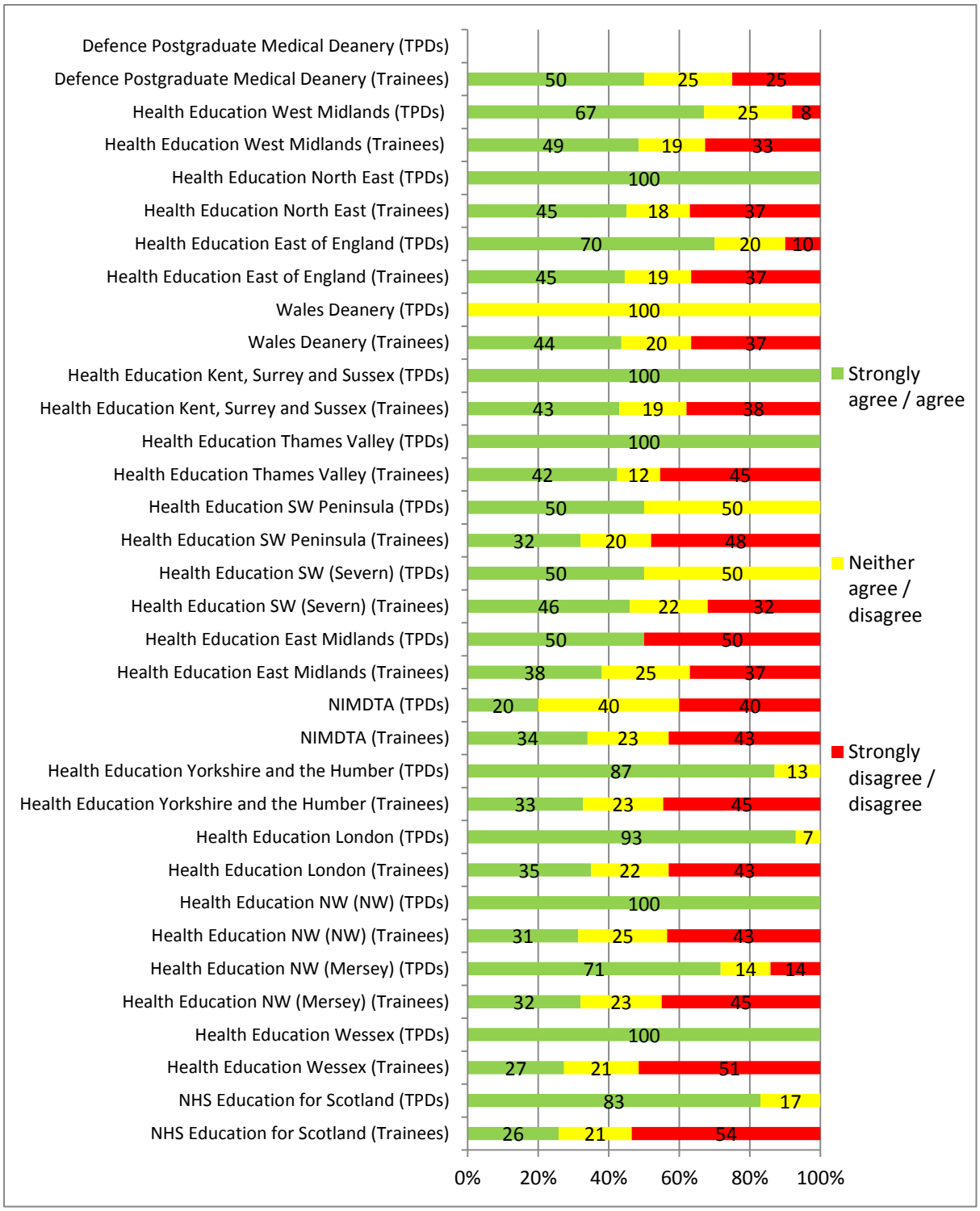
B5.1 92% of TPDs (66/72 TPDs) compared to 62% of all CMT trainees (1831/2947 trainees) agreed CMTs normally receive a minimum of one hour curriculum-relevant teaching on average a week.

B5.1 Training Programme Director / College Tutor comments (17)

- Built-in the weekly teaching programme
- Attendance at these teaching sessions is poor and we are looking to 21organize21m some of our sessions
- Trainees attendance is poor because of the various on call commitments
- In our hospital, the direct observation is less likely to happen compared to the 21organize21m relevant teaching.
- Usually 2 hours/week.
- We have now moved to a 3 hour slot every other week so that clinical cover on the ward can be planned better
- Way more, regional teaching is monthly as well as professional development days and local teaching Again the standards document is weak on regional teaching
- 2 hour teaching slots every Thursday
- CT2s have often been certified competent and don't require further observation
- Too high a level of cancellation at local LEP level
- Not quite sure about this question as there are 2 separate questions. They receive 1 hr of curriculum relevant teaching (2nd part of question) but do not receive weekly directly observed….. PACES teaching comes in blocks and is much more intense than just weekly 1 hour.
- We provide 1 hour a week consultant led teaching based on the curriculum, 1/2hours of SpR provided symptom based or trainee directed learning. For 6 week pre-PACES daily teaching is available for each diet.
- Improvements planned for August, however successful once monthly all day teaching has considerably improved access to education.
- 2 hour a week of protected curriculum based teaching along with bedside PACES style teaching as well.
- PACE teaching harder to 21organize. Depends on commitment of those attending as well as those teaching.
- Top 20' teaching x1 week, grand round x1 / week + departmental teaching in all specialties
- 2 hours provided locally per week and PACEs sessions organised when relevant

B.5.2 A minimum of one hour curriculum-relevant teaching per week on average, to include a regular rolling programme of direct observation of clinical skills around the PACES diet.

Q. In this post I have had regular teaching, including direct observation of clinical skills, relevant to passing PACES



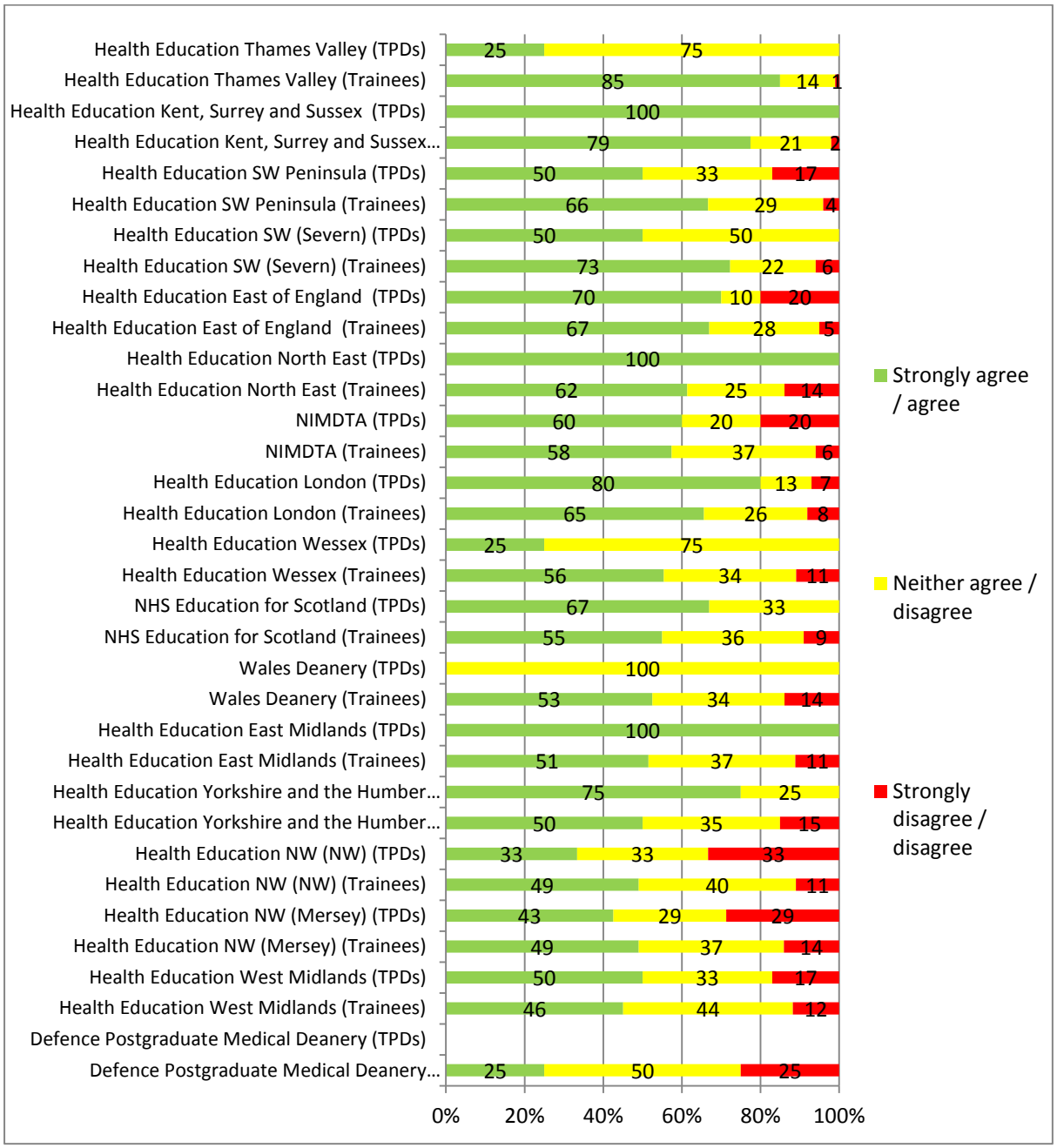
B5.2 76% of TPDs (55/72 TPDs) compared to 35% of all CMT trainees (1021/2947 trainees) agreed that in the post CMTs had at the time of completing the survey, they had regular teaching, including direct observation of clinical skills, relevant to passing PACES.

B5.2 Training Programme Director / College Tutor comments (19)

- Built-in the weekly teaching programme as rolling 6-8 weeks before each exam date.
- The teaching is delivered depending on the trainees needs. Most of our trainees are CMT1 and they prefer teaching geared to MRCP written exam.
- Clinical material covering the full range of typical PACES cases is not always easy to access on GIM wards these days. In undergrad medicine we have therefore found it necessary to set up dedicated clinical teaching days. We might need to follow a similar model for PACES.
- This unfortunately is ad hoc
- Most Trusts run PACES teaching and this is something we are keen to develop further.
- Most CTs will pass PACES in CT1 so different skills need building on for CT2. The needs for this will vary with each cohort of trainees and so will not be throughout the year.
- There is PACEs teaching in all units some better than others. Plans to incorporate this into regular teaching sessions.
- We arrange regular blocks of PACES teaching in the weeks prior to the exams.
- Although much on informal basis as teaching program has been more curriculum focused
- Currently we are setting up regular PACES teaching but this has not been the case until now.
- Depends if trainees arrange PACES teaching directly with consultants.
- Previous bedside teaching programme dismantled in the last 2-3 years
- They can get this in preparing for PACES. Few seem to want it before that
- But is ad hoc
- We have trainee rep organised regular PACES teaching
- As above
- Depending upon how active they are in chasing their training needs.
- Not part of the current culture - available but arrangements tend to be trainee-led at time of exam preparation
- Primarily delivered as part of post-take ward rounds or specialty ward rounds but a PACES training programme has been developed particularly for trainees in the run-up to their PACES exam.

C.1 Evidence of trainee representation and engagement in appropriate local professional and education committees, e.g. Trust education committee.

Q. In my current Trust, CMT trainees are normally represented on appropriate professional or education committees.



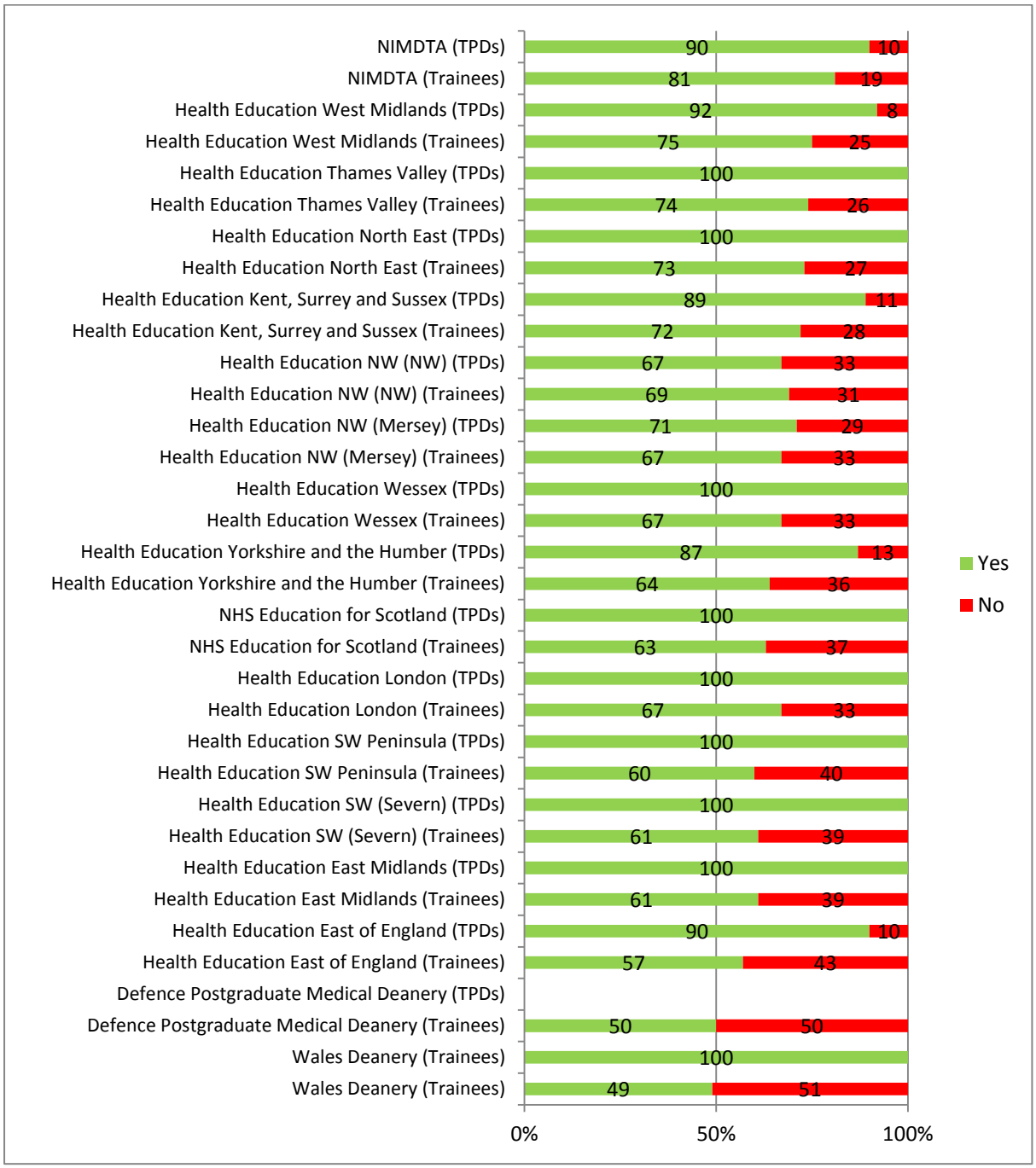
C1. 61% of TPDs (44/72 TPDs) compared to 56% of all CMT trainees (1660/2947 trainees) agreed that in their current Trust, CMT trainees are normally represented on appropriate professional or education committees.

C1. Training Programme Director / College Tutor comments (23)

- Local CMT representative
- Been invited but no trainee agreed to be the representative on the committee.
- We do have 2 associate RCP Tutors in Hull and 2 Regional CMT reps in HEYH Yorkshire (North & East)
- It has been difficult in recent times to engage trainees eg associate college tutor post, TEC
- Trainees on our regional meetings but I have no data on trust education committees - they clearly should be
- They are invited to the local LFG but unfortunately, rarely come
- Have a junior doctor and registrar representative, have associate college tutor
- Piecemeal engagement despite advertised opportunities
- This is a large Trust and CMTs have representation at local faculty groups but not necessarily at Trust level. I have no input at Trust level meetings.
- Trainees (Core and Associate College Tutor) are invited to attend the Medical Faculty and PGME Boards
- CMT forum regionally and also junior doctor forum within LEP
- formal education committee in development still
- We have an SpR on MEC who is our Senior Resident
- Associate college tutor in place. Junior doctors' fora hosted by Clinical Tutor.
- We have committees in place but the interest from CMTs specifically is not always there but its available
- Not happened yet, but plan to engage trainees to attend medical education quality committee. Trainees do attend CEO/ MD trainee forum which is quarterly.
- Associate CMT representative elected and is invited to attend
- Trainee representative at board of medicine meetings
- I have reviewed the CMT QC baseline adherence in our region and have found that excepting in our Trust we do not have a very good CMT representation in Ed Coms in other Trusts. Due to the experience in our Trust I, as the CMT Quality Lead of our region, have recommended that there should a CMT rep for every 10-15 CMTs. I am happy to share more information if required.
- Reps at all LFG meetings
- Something I'd look to raise in the near future.
- CT1 and CT2 trainee representatives attend CMT Training Committee Meetings Each Trust has a trainee forum covering all specialties
- A Trainee representative is invited to attend the LAB (Local Academic Board meeting) and trainee representatives also attend and report to each of the Medical LFG meetings.

C.2 An introduction to the system of review and assessment at a departmental level (to include ePortfolio use) to be provided within one month of starting.

Q. I had the opportunity to attend a department introduction to the system of training assessment and review within one month of starting the CMT programme.



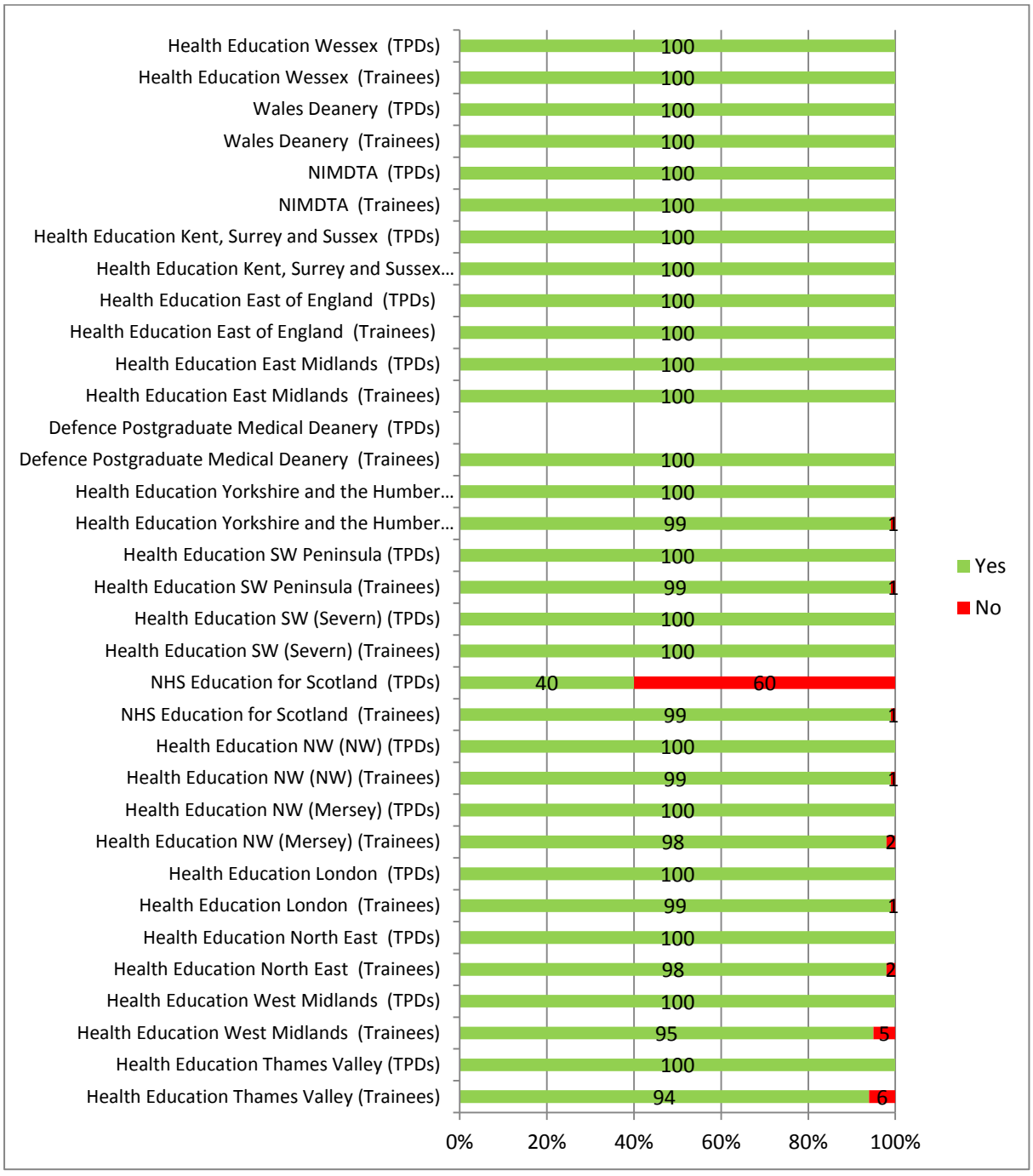
C2. 92% of TPDs (66/76 TPDs) compared to 59% of all CMT trainees (1759/2947 trainees) agreed that CMTs had the opportunity to attend a department introduction to the system of training assessment and review within one month of starting the CMT programme.

C2. Training Programme Director / College Tutor comments (19)

- Scheduled Generic day August-September
- I am not sure what this question is driving at.
- This is done at each LEP in August and regionally in September
- This occurs in the majority of cases. However, a minority are on call for the first 6 weeks (trainees do 6 week blocks on call), so are not able to arrange a convenient time with their ES for induction.
- Although as the JRCPTB changes ARCP decision aids, often in the middle of a year and without notification to either trainers or trainees this introduction may not be relevant.
- By departmental this is assumed to mean Core Medicine rather than specialty department and this is delivered by College Tutor.
- In most cases
- 1. Brief into at induction with follow up email with ARCP decision aid etc. 2. Formal 'teaching' session within first month 3. 1:1 review by College Tutor for all at 3-4 months
- I do an hours teaching on the use of the CMT eportfolio and teaching provision in the first 2 weeks locally and further teaching is provided regionally. Each department provided Clinical Supervision and there is an expectation that it includes training agreement and departmental induction
- Via post induction meeting
- Part of induction
- This is not a departmental matter it is a programme matter and is dealt with at a Regional programme induction
- This is primarily provided as a regional induction event in the 2nd week of CT1
- Achieved at most times
- We have a monthly monitoring scheme whereby the progress is charted from first month on wards
- As part of induction
- Regional provision but also delivered locally, Small numbers
- All receive one to one supervision covering these within their first month.
- Although due to administrative issues centrally, neither the new CMT trainees or their educational/clinical supervisors were able to access the e-portfolio for the 1st month of their placements.

C3.1 A named College Tutor, or equivalent CMT Lead, appointed in all trusts to oversee CMT training.

Q. My current Trust has a named senior member of staff or College Tutor appointed to oversee CMT training.



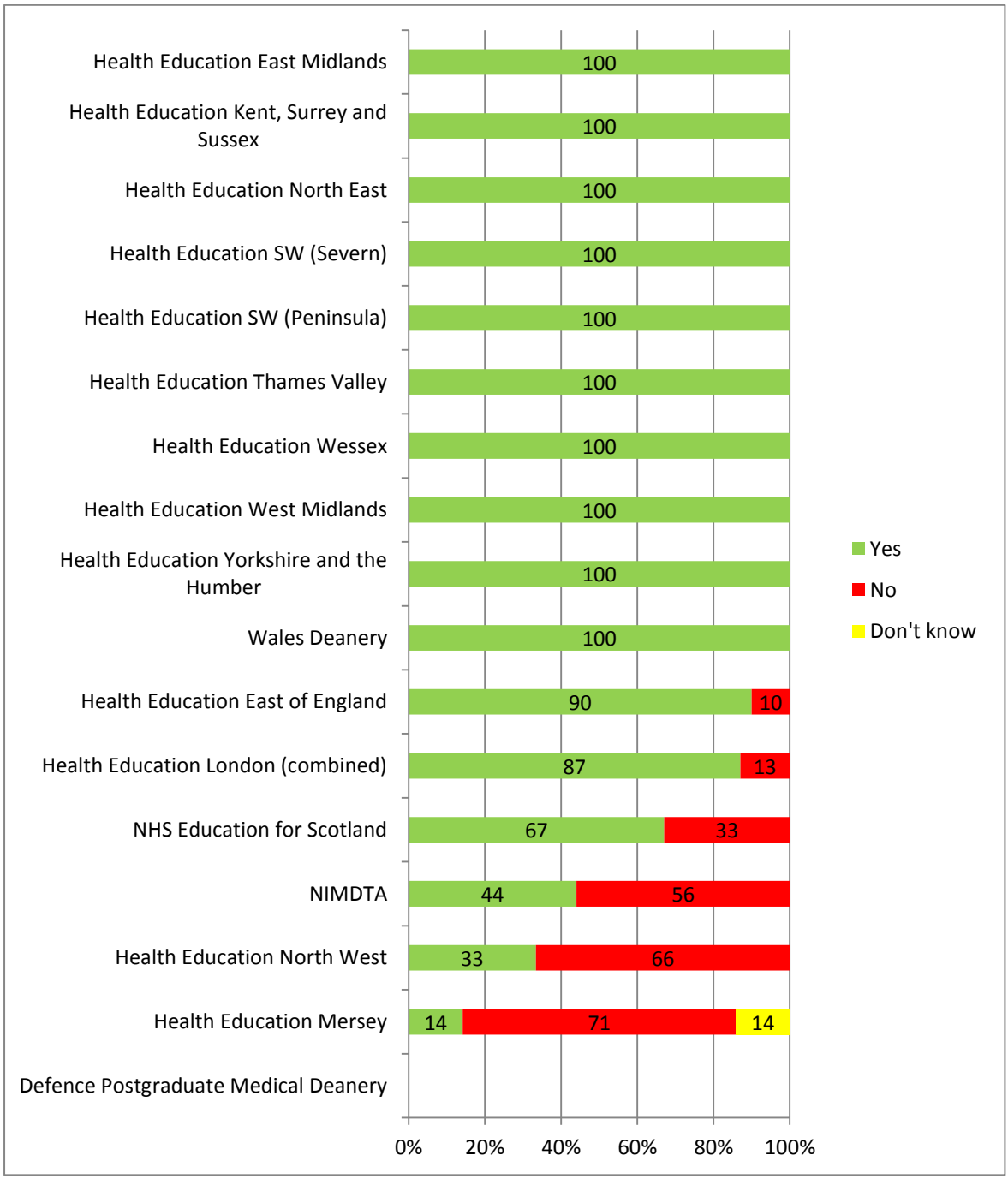
C3.1 97% of TPDs (70/72 TPDs) compared to 87% of all CMT trainees (2555/2947 trainees) agreed that their current Trust has a named senior member of staff or College Tutor appointed to oversee CMT training.

C3.1 Training Programme Director / College Tutor comments (11)

- Each site in each trust (some are massive) where ever possible - called local TPDs
- In reality I get one PA to do this but it takes much more than that so I will do a lot of the admin and e portfolio monitoring after hours
- 1 PA : 24 trainees
- Me
- Myself
- In our Trust the College Tutor is responsible for all postgraduate trainees and supporting all medical faculties - quite an impossible task. Need a separate unit training director for medicine and a College Tutor in DGHs
- We have 2 - works well (most of the time)
- However, would expect so.
- Resources put into appointment vary greatly among Trusts
- NHS Grampian TPD coordinates for NHS Highland, Shetland and Western Isles
- Although this post is not adequately recognised in the job plan and no extra remuneration is available.

C4.1 Each trainee to have a single, named educational supervisor for a minimum of 12 months, who has been selected trained and assessed as per national guidance. The supervisor's duties and training time will be specified in their job plan according to national guidance.

Q. Does each trainee have a single, named Educational Supervisor appointed to oversee their CMT training for a minimum of 12 months?



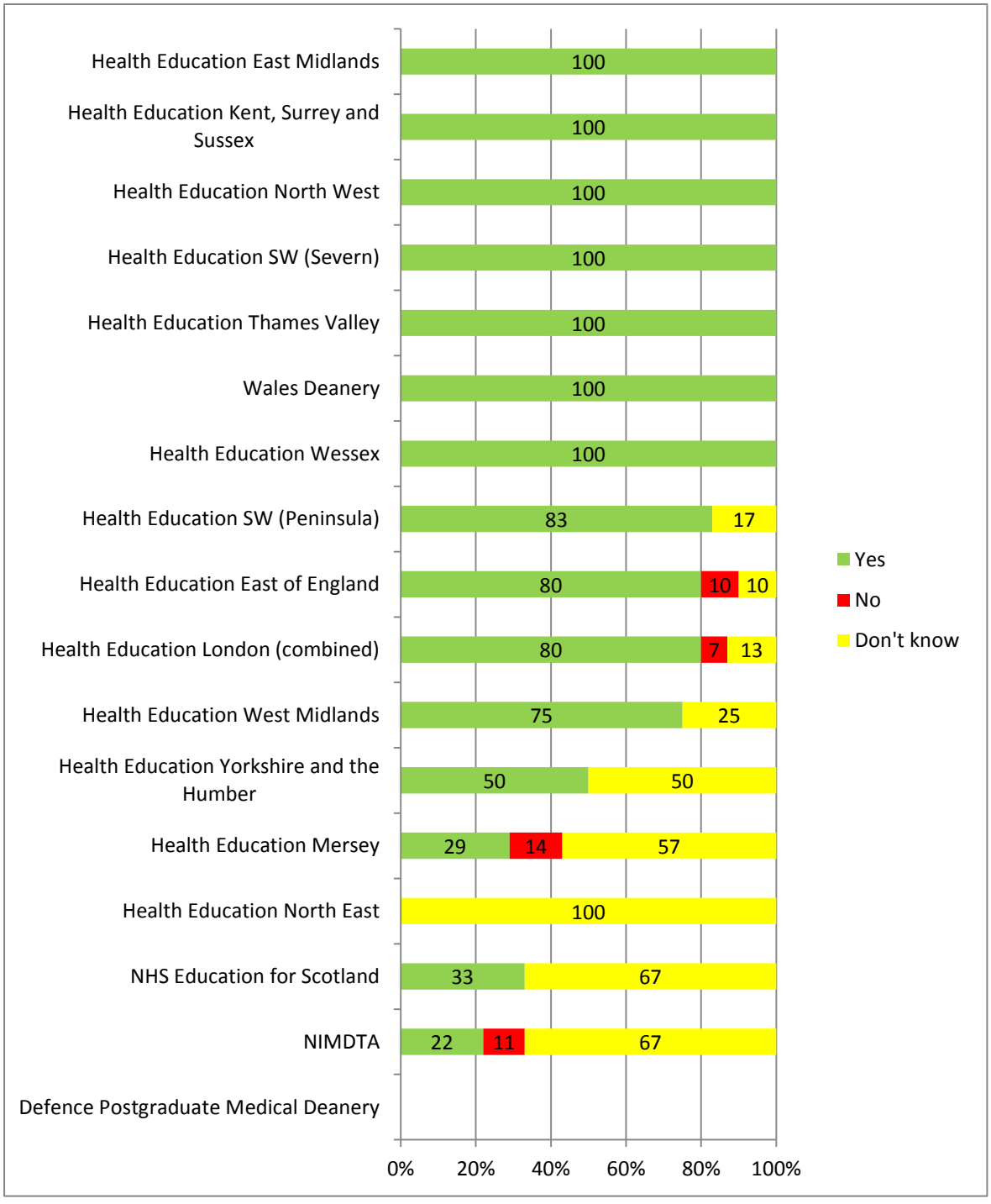
C4.1 85% of TPDs (61/72 TPDs**)** agreed that each trainee has a single named educational supervisor for a minimum of 12 months, who has been selected trained and assessed as per national guidance.

C4.1 Training Programme Director / College Tutor comments (22)

- The ES in our Trust moves with each rotation
- We aim to introduce this in August
- But I do not feel confident that either the job planning of this time is actual and real. Neither am I confident that the ES's deliver what is on the Job Plan when it is.....
- They will from now on but due to trainees only spending 4/12 on this site at a time they have previously changed ES according to their site
- Due to geographical distances we have used 2 supervisors previously. we are using one this year
- Not all supervisors have specific allocated time in their job plan
- Educational supervision may be for 6 months placement only
- We have the ES but many do NOT have appropriate time in their job plans this is on-going with Trust
- Policy in HENW-Mersey to run 4/12ly educational supervision
- Our supervisors change with each post. We feel strongly this is better than a 12 month supervisor
- Educational supervisor for each post. The baton then hands on to the next supervisor. College Tutors oversee the progress during the whole year.
- We do it for the whole 2 years of the CMT training at a time
- For 2 years
- 6 month turn around
- ES changes every 6 months as trainee moves post.
- Usually within Northern Ireland supervisors are for 6-month periods.
- ED is appointed for duration of rotation in each hospital , it will be 6 months if trainee moves to other hospital
- 6 month rotations, therefore 2 ES during this time frame.
- 1 ES per each 6 month post
- 1 supervisor for each block
- for 2 years
- Education supervisor is in 2 x 6 months blocks - due to geography of attachments. This works well. There is easy access to previous ES comments / instruction on eportfolio.

C4.2 Each trainee to have a single, named educational supervisor for a minimum of 12 months, who has been selected trained and assessed as per national guidance. The supervisor's duties and training time will be specified in their job plan according to national guidance.

Q. Have all Educational Supervisors been selected, trained and assessed as per national guidance?



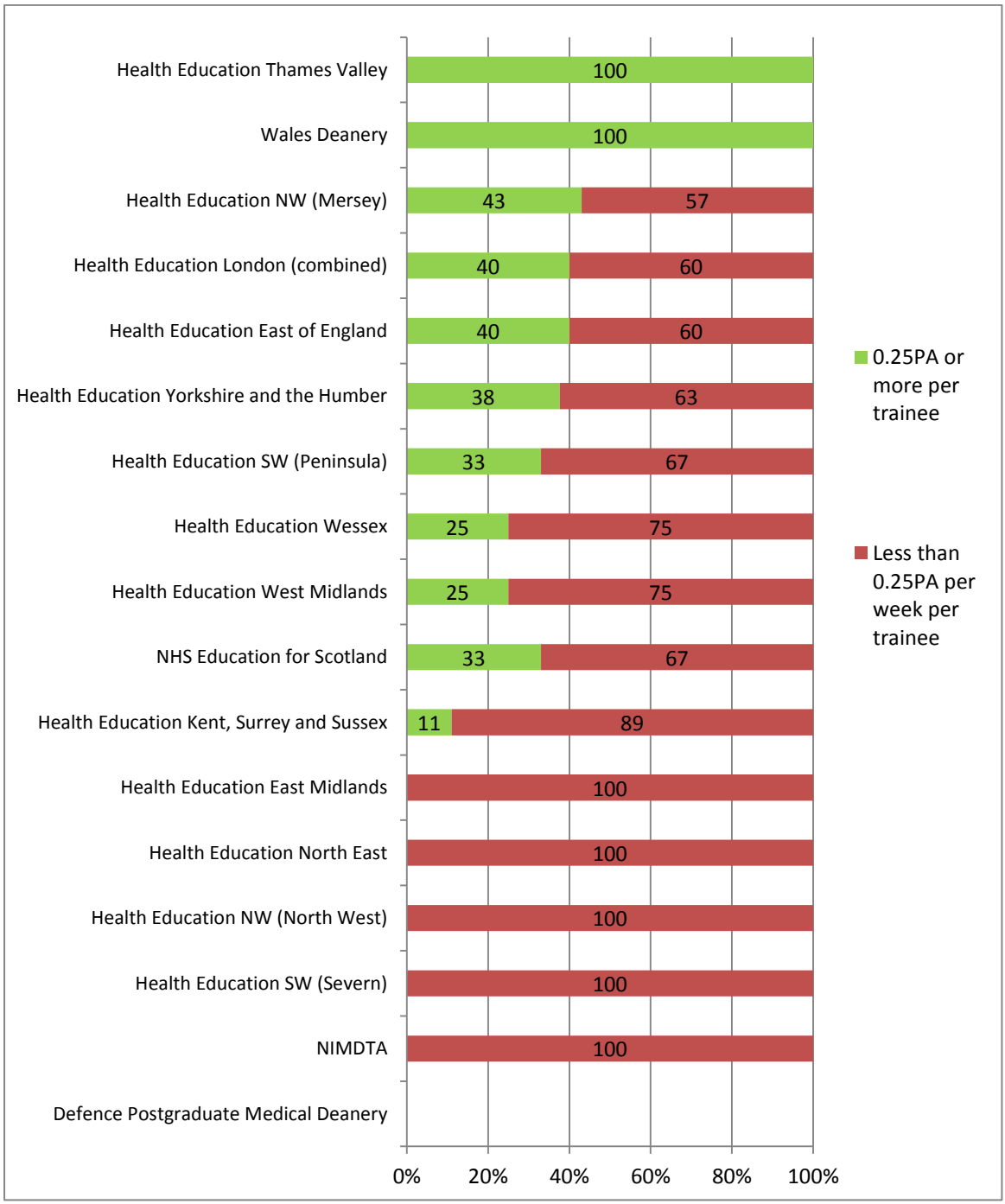
C4.2 74% of TPDs (53/72 TPDs**)** agreed that all Educational Supervisors been selected, trained and assessed as per national guidance.

C4.2 Training Programme Director / College Tutor comments (11)

- I believe so but have not reviewed the register.
- Monitoring of Educational Supervisor training is done more centrally via Director of Medical Education
- Our Trust is currently logging all educational training for supervisees.
- Training ongoing
- Needs to be more robust and job planning needs to support time for ES which is not so at present
- The majority if not all. LEPs keep a good check on these
- But too difficult to get training!
- All appropriately trained as per QUESP and RCP educators training
- Within my hospital, yes. Would expect, but cannot vouch with certainty for others.
- Many but not all of them are trained Training is to be completed by each ES by 2016
- This information is collated at Trust level

C4.3 Each trainee to have a single, named educational supervisor for a minimum of 12 months, who has been selected trained and assessed as per national guidance. The supervisor's duties and training time will be specified in their job plan according to national guidance.

Q. On average, how many PAs per week do Educational Supervisors have allocated specifically for supervision duties per trainee?



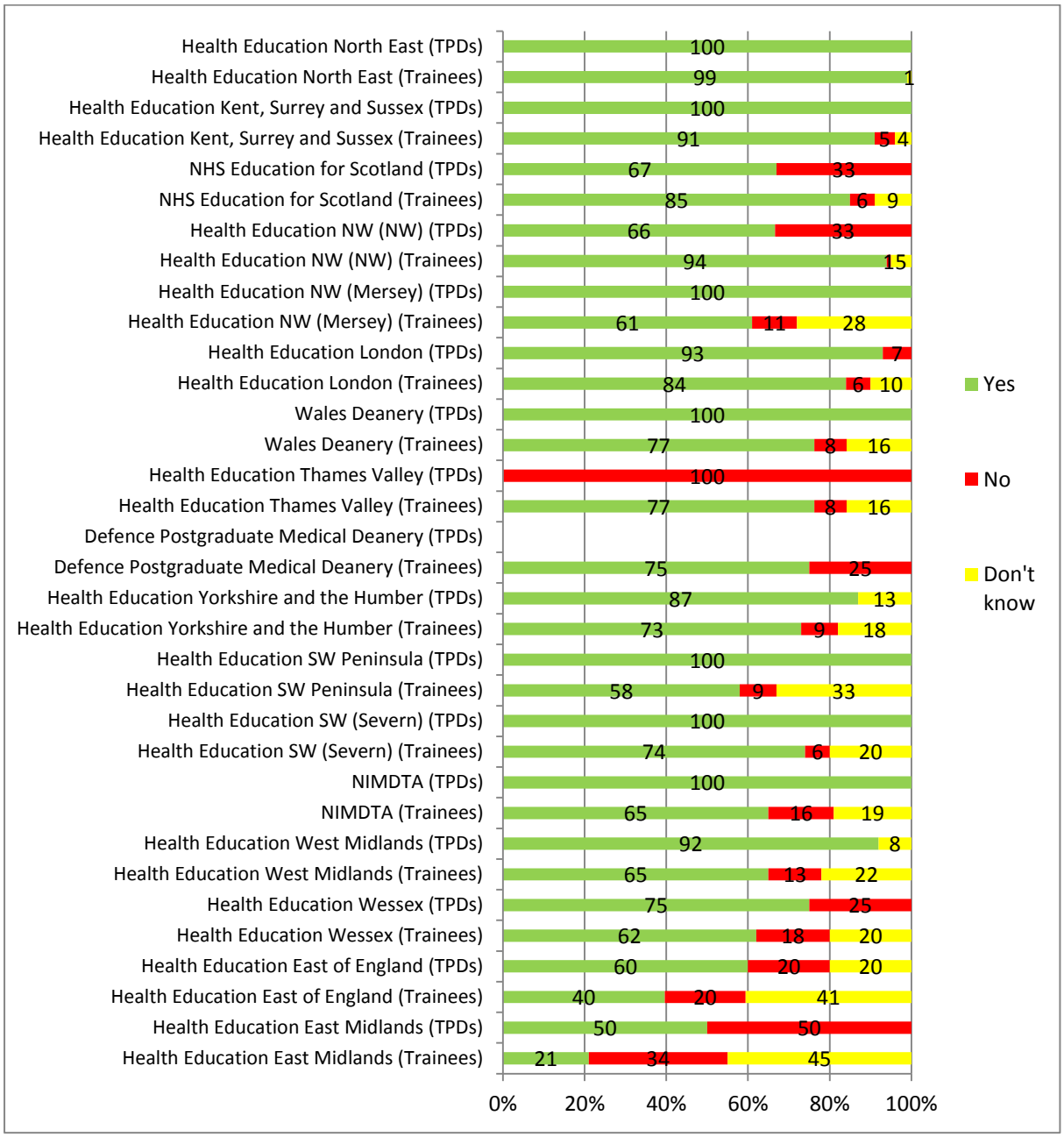
C4.3 33% (24/72 TPDs) agreed that on average, Educational Supervisors have 0.25 PAs per week per trainee allocated specifically for supervision duties.

C4.3 Training Programme Director / College Tutor comments (21)

- Currently all consultants are going through job planning process, ? reduction of supervision Pas
- Supposed to be 0.25 per trainee. Don't know of this is actually acknowledged in the job plan.
- Difficult to be certain exactly. I do not have access to all job plans
- This is not currently formalised into job plans in our Trust.
- In Hull E. Supervisors are allocated time for supervision, but can be varied from the Departments to departments. It is unlikely that they receive 0.25PA per trainee per week (less than 0.25PA per trainee)
- Trust policy that 0.25 per week per trainee but unclear whether that is delivered
- Since this is agreed locally by each department we may always be aware of the exact allocation.
- None
- Lost all faith in job planning process in Medicine
- 0.25 per trainee for ES the real problem is with the CS's
- There is not clear provision on the job plan for educational supervision in most cases
- I cannot answer this specifically as I am not party to individual consultant job planning but am giving my best guess.
- Our post graduate department are looking to achieve funding to go directly
- Not sure that anyone on 1 2.5 PA contract has any additional PAs and also not sure that we have really established a formal PA system for those new consultants on a 1.5 SPA contract to have educational supervision added. It may happen for some but is rather ad hoc.
- This is supposed to be the case, however job planning has not been good in this Trust.
- Large number of none deanery based trainees with no funding source requiring supervision.
- Only 0.125 PA per trainee. No time allocated for clinical supervision or MCR which is increasing becoming demanding.
- On-going battle within Trust
- 0.125 per trainee
- Trust has taken steps to ensure 0.25 PA per trainee (for up to 4 trainees) in the next year
- Currently 0.125 PA but due to go up in December 2015 to 0.25 PA
- 0.25 desirable but ES complain less in reality
- Steps are being taken to remedy this situation
- 0.375 for 6 trainees
- 0.08 PA per trainee
- Though I accept at 0.07PA per trainee, I may be more or less than others.
- In my trust , no PAs allocated
- In Belfast Trust currently 0.25 PA for 4 trainees
- In some Trusts there is no recognition
- There is often inadequate provision for educational and clinical supervision and other educational duties (such as College Tutor roles) in job plans. It is difficult to protect SPA time and the clinical workload often means SPA time is used for DCC.

C.5 Formal interim reviews (also known as a 'pre-ARCP appraisal') involving a TPD (or equivalent) to be provided to all CMT trainee's pre-ARCP and the outcome recorded in ePortfolio.

Q. I had, or will have, a formal interim review (also known as a 'pre-ARCP appraisal') before my ARCP.



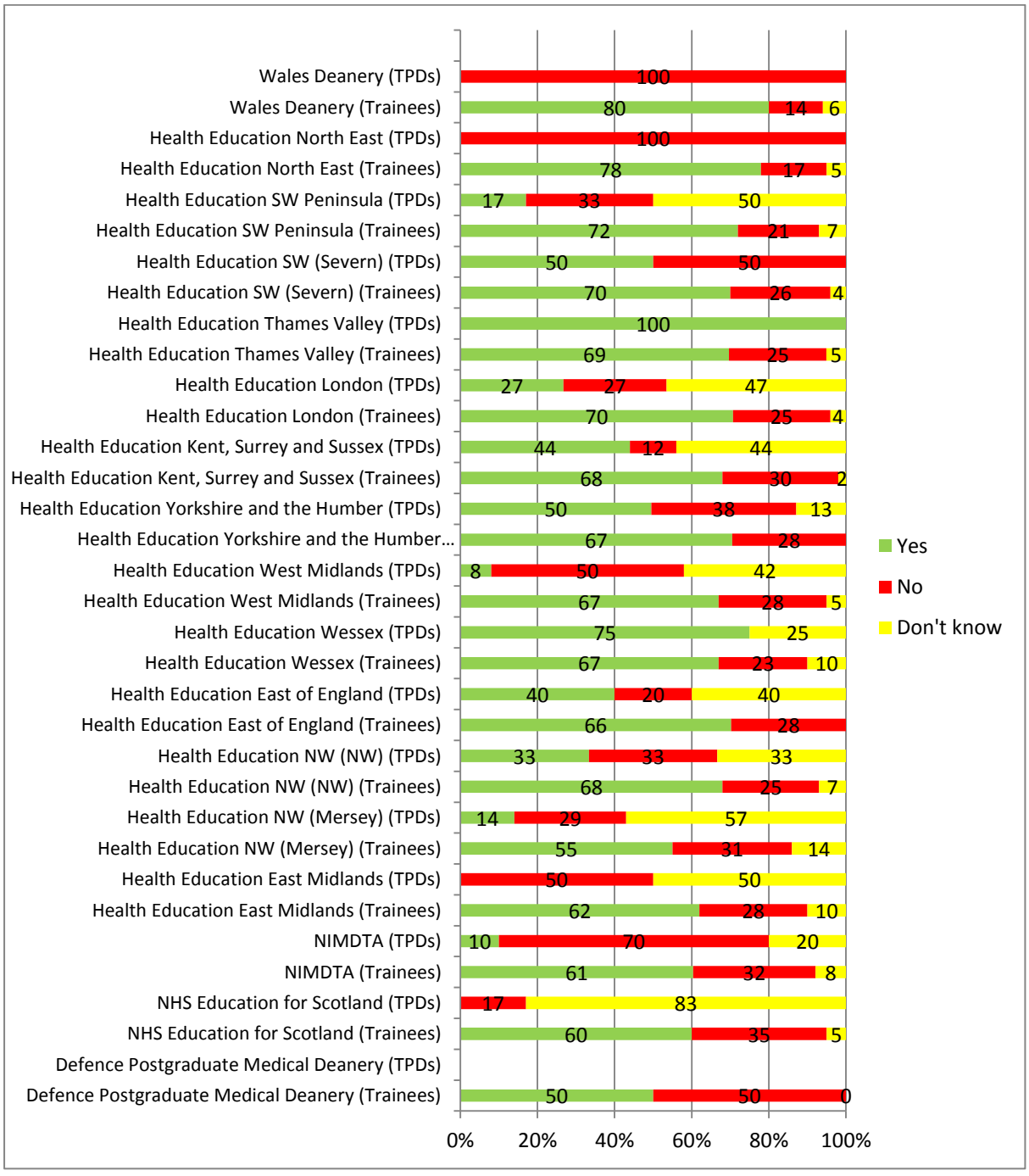
C5. 85% of TPDs (61/72 TPDs) compared to 71% of all CMT trainees (2105/2947 trainees) agreed that CMTs had had, or will have, a formal interim review (also known as a 'pre-ARCP appraisal') before their ARCP.

C5. Training Programme Director / College Tutor comments (14)

- College tutor undertakes a pre ARCP review of portfolio. Trainees are also asked to complete a survey monkey self-assessment of their eportfolio by the TPD around month 4
- We always do this as a zone.
- Called interim review
- This has been problematic this year with changes in postgrad centre. We are improving things for next year.
- has happened informally but a formal process is being introduced
- In December and April
- This is not recorded in eportfolio. Many of them have quite a bit of catching up to do and I am not sure they would want all of the details kept in perpetuity on their portfolio!. They are sent a summary of what needs to be done followed by meetings & emails etc. for the recalcitrants.
- I meet will all 19 trainees personally and go through their eportfolio 2-3 months pre-ARCP
- I do this with trainees
- There is no formal interim review done but regular discussion with the trainees about ARCP Decision aid and also discussion with the supervisors.
- Known as 'interim review'.
- Not all but majority
- Yes but not recorded in eportfolio. Will be recorded in future.
- Difficult to do - we have a monthly review of portfolios from beginning. Due to workload the pre-ARCP meeting do not happen
- But it should be uploaded electronically, no have to be scanned and emailed
- 1or 2 as per trainee need
- Usually performed by TPD, and recorded within trainee's portfolio, with advice regarding needs and gaps requiring intervention prior to ARCP.
- Called an interim review - this year was performed by myself, TPD electronically
- All have a meeting but locally rather than with TPD
- This is delivered by the College Tutor/Medical LFG lead and not the TPD in most cases, unless the TPD is an employee of that individual Trust.

C.6.1 ES and trainee to discuss and agree a plan for MRCP (UK) training, to include 'before and after' meetings around the examination. Trainees requiring more support should receive enhanced training and / or supervision.

Q. I have agreed, or will agree, a plan for MRCP(UK) training with my Educational Supervisor before attempting the examinations.



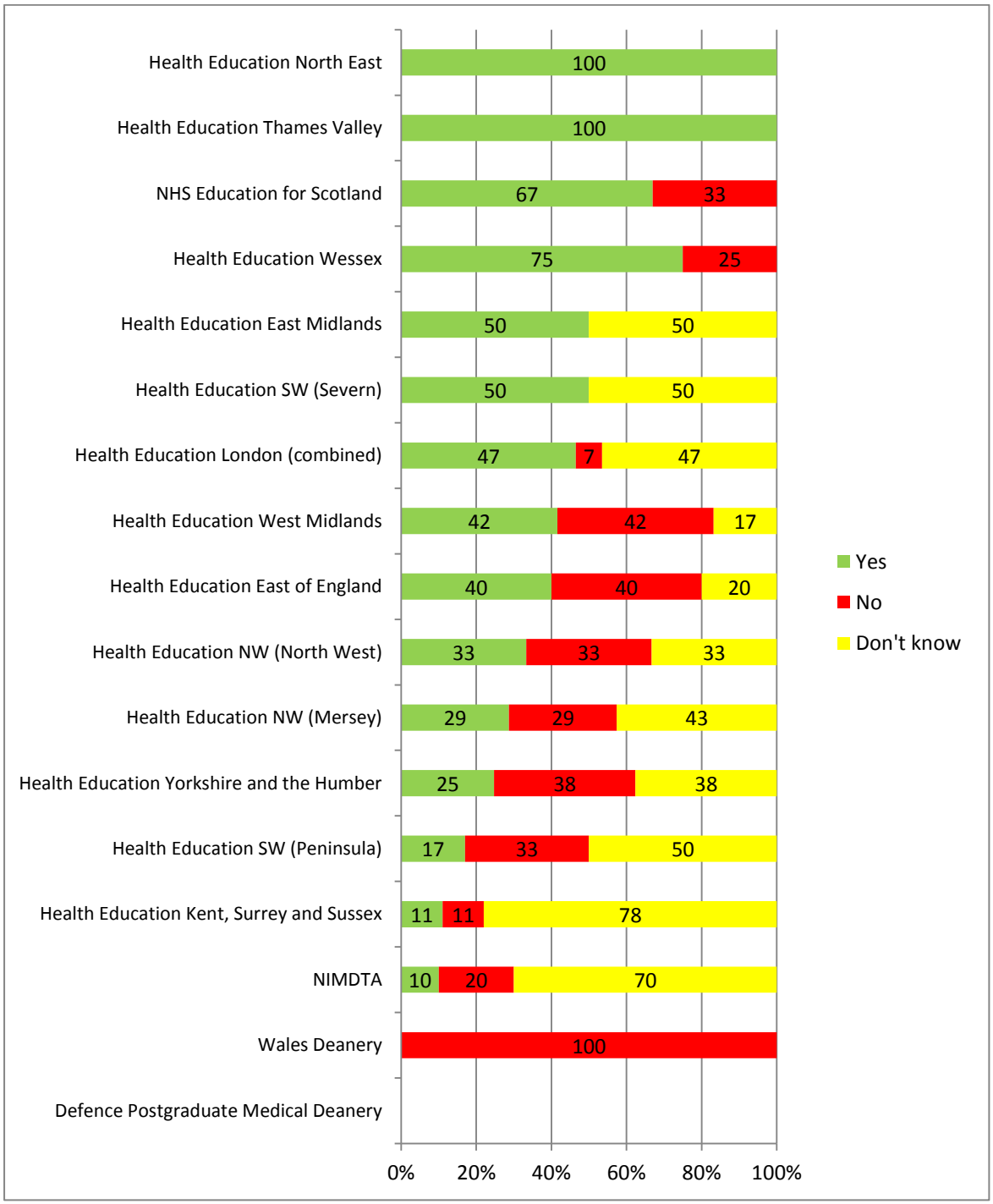
C6.1 29% of TPDs (21/72 TPDs) compared to 55% of all CMT trainees (1622/2947 trainees) said that CMTs have agreed, or will agree, a plan for MRCP(UK) training with their Educational Supervisor before attempting the examinations.

C6.1 Training Programme Director / College Tutor comments (22)

- But mostly informal and not documented. Locality PACES teaching Regional two day PACES Course and mock exam
- Hard to know how much this happens. I know that I always talk about exams.
- I think they make their own decisions re MRCP. They may talk it over with their supervisor and with myself, but I feel that they are adults and can make these decisions themselves. Quite honestly I think they are more guided by their peers than anyone else.
- Nobody has ever asked me for this
- Not formalised, likely to be happening much of the time in ad hoc fashion
- Not happening formally.
- Probably not a formal discussion, but some have informal ones. Interestingly, the majority our current intake had MRCP prior to starting!
- There is a process by which all trainees can approach to TPD, D-TPDs, RCP Tutors, Associate Tutors and Trainees reps to support to pass the exams (all components). Exam materials are available on line, local teaching for PACES and the School of Medicine
- There is limited evidence of this in some portfolios, but not all.
- This does not happen routinely but is improving
- This does not seem necessary. Most trainees know what they need to know and if they don't they ask for advice. Educational supervisors are busy and it is a waste of resource to keep adding in extra requirements without evidence that they impact outcomes
- This is discussed at induction with the ES.
- This is discussed in most portfolios reviewed but not formalised
- This will start in August 2015
- Variable depending on the ES.
- We need to move to this.
- Probably informally
- They would have but not necessarily labeled as MRCP planning.
- Generally, but not infallible
- Many have no formal plan agreed with supervisor prior to exams
- But no enhanced training offered
- MRCP exams are discussed at Educational Supervisor meetings and at the pre-ARCP interim reviews. Study leave funding is available for PACES courses

C.6.2 ES and trainee to discuss and agree a plan for MRCP (UK) training, to include 'before and after' meetings around the examination. Trainees requiring more support should receive enhanced training and / or supervision.

Q. Do, or did, all trainees identified as requiring more support with examinations receive enhanced training and / or supervision?



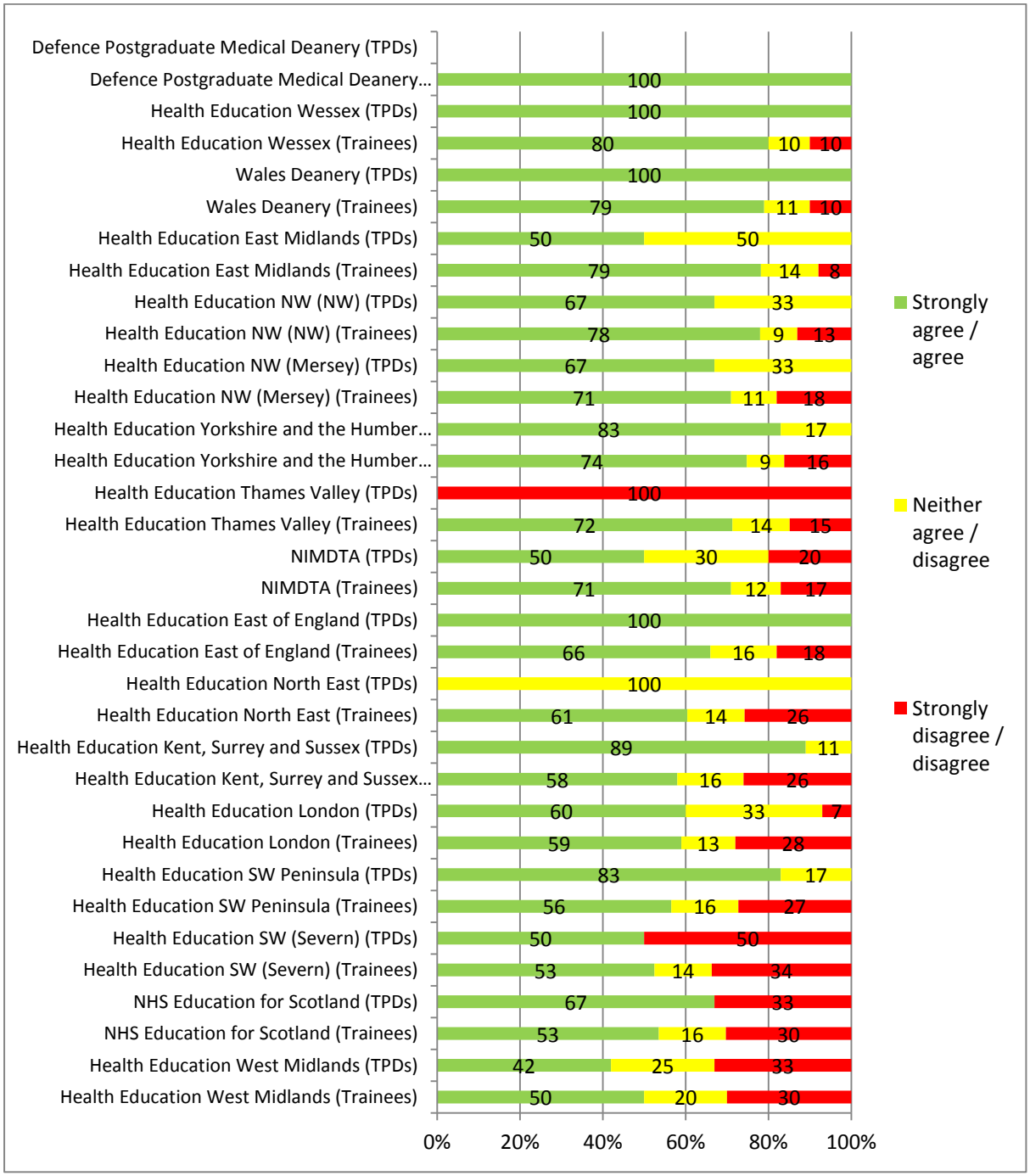
C6.2 40% (29/72) TPDs agreed that all trainees identified as requiring more support with examinations receive enhanced training and / or supervision.

C6.2 Training Programme Director / College Tutor comments (23)

- As above
- Limited evidence of identification of trainees requiring support
- As above
- Some have been given much additional support to great effect.
- PACES training is trainee driven. We usually have more trainees than faculty to run the training.
- For those identified to me....
- Trainee support service offered and action plan with ES
- only PACES failures, I&II failures have some suggestions about study but not enhanced training
- I don't think we had any trainees who had difficulty with MRCP
- Easy access to support
- But we have had very few. They will get study leave for courses and can have personal study leave for revision (not generally allowed) and can be referred to the deanery for support if they wish. A few have taken up that opportunity.
- They have been offered support...but not all wish to take it up.
- Faculty development group meeting and discussion about trainee in difficulty. Identified trainee are supported regularly.
- Many of those clearly identified did get support. Some trainees only know they're not doing so well after the fact.
- regional PD offers this
- Each trainee needs to engage with tutors to arrange.
- Some did, but other CMTs do not engage
- Most of the work is done by the college tutor. There is little involvement from other consultant colleagues to commit to teaching.
- Some more engaged than others
- only one needed remedial
- yes to supervision locally but enhanced training regionally or from RCP seems lacking
- some but not all, I suspect, have additional support
- Our trainees have a very high pass rate in MRCP and to my knowledge we have not identified any trainees that required more support or enhanced training.

D1. Information on expected CMT rotations to be published at the time of job offers.

Q. At the time of my job offer, I was given enough information about the possible rotations within the CMT programme.



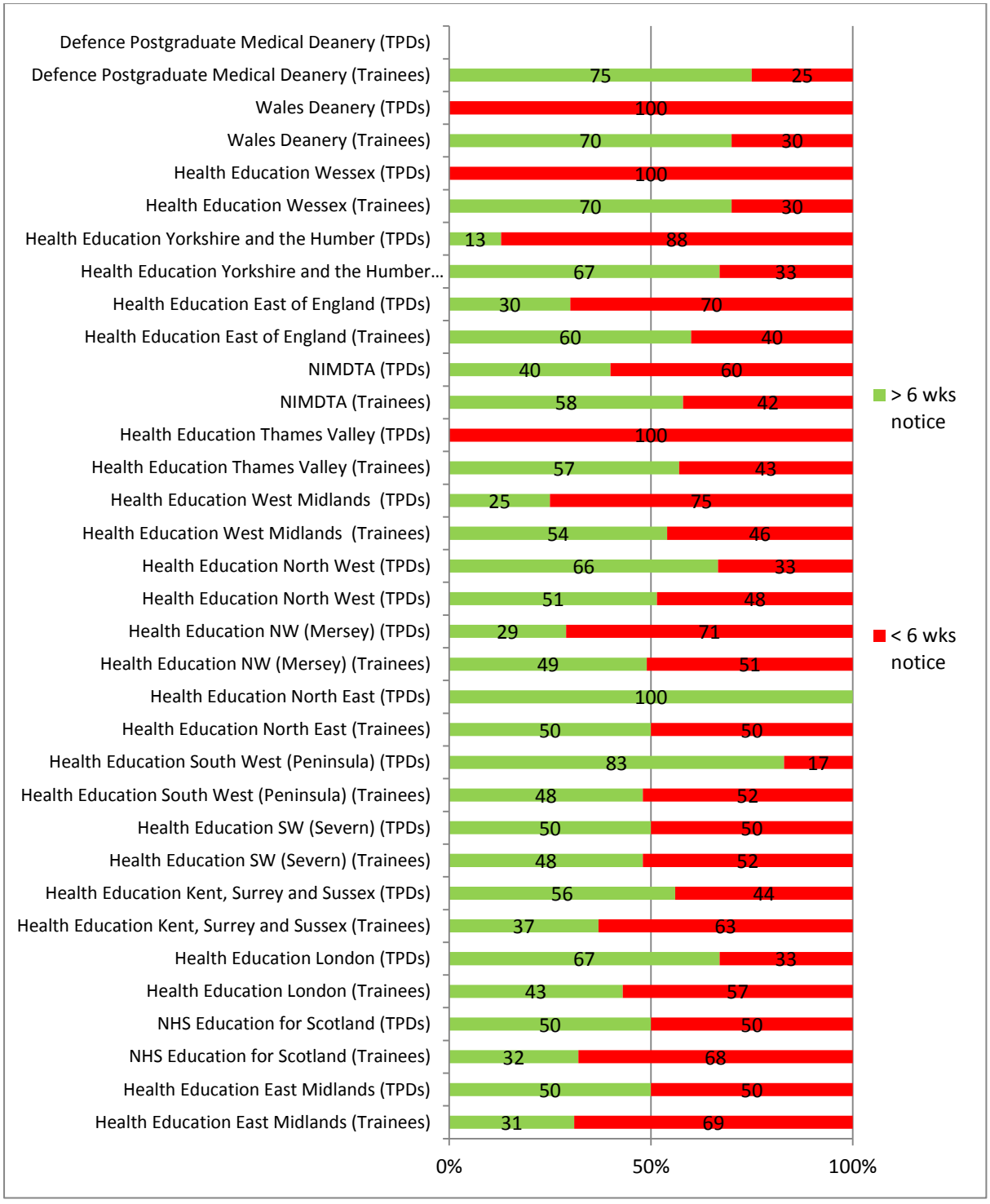
D1. 65% of TPDs (47/72 TPDs) compared to 66% of all CMT trainees (1935/2947 trainees) agreed or strongly agreed that at the time of their job offer, CMTs were given enough information about the possible rotations within the CMT programme.

D1. Training Programme Director / College Tutor comments (15)

- Do not know
- Offers sent by the deanery. Not sure what information is given out at the time.
- I don't think this is applicable to me as a College Tutor in a DGH. This is a question for the TPD.
- Could be improved.
- We advertise as far ahead as possible. All posts are advertised as being subject to change - mainly to allow ourselves some room for changes in case the JRCPTB change these quality standards to mandated requirements. This would not be necessary if the JRCPTB gave a clear timeline as to how whether this will happen with an adequate lead in time.
- Don’t know
- Details on 2 year rotations available at time of interview
- I don't think they have enough info quite honestly and would like this to change. Quite difficult with 'in out' rotations and liaising between several hospitals. Was able to provide this when we had 2 year rotations in the same hospital.
- We think enough is given but you should really ask trainees this
- Via TPD/ deanery
- Only for CMT year 1 not year 2
- Things change based on trainee requirement and choice
- I don’t know as this is overseen by the KSS deanery
- Until recently, trainees had no idea at CT1 level where they might be for CT2.
- Although I strongly disagree with the notion that publishing specific details of the training programme for the whole 2 years is necessary of helpful. This reduces the ability of the Trust to adapt the programme or to deal with unforeseen vacancies. It also reduces the ability for trainees to change their programmes as their sub-specialty interest’s change and develop as their training progresses.

D2.1 On-call rotas to normally be published at least six weeks in advance and cover four months in length.

Q. How much notice are you usually given for your on-call rotas?



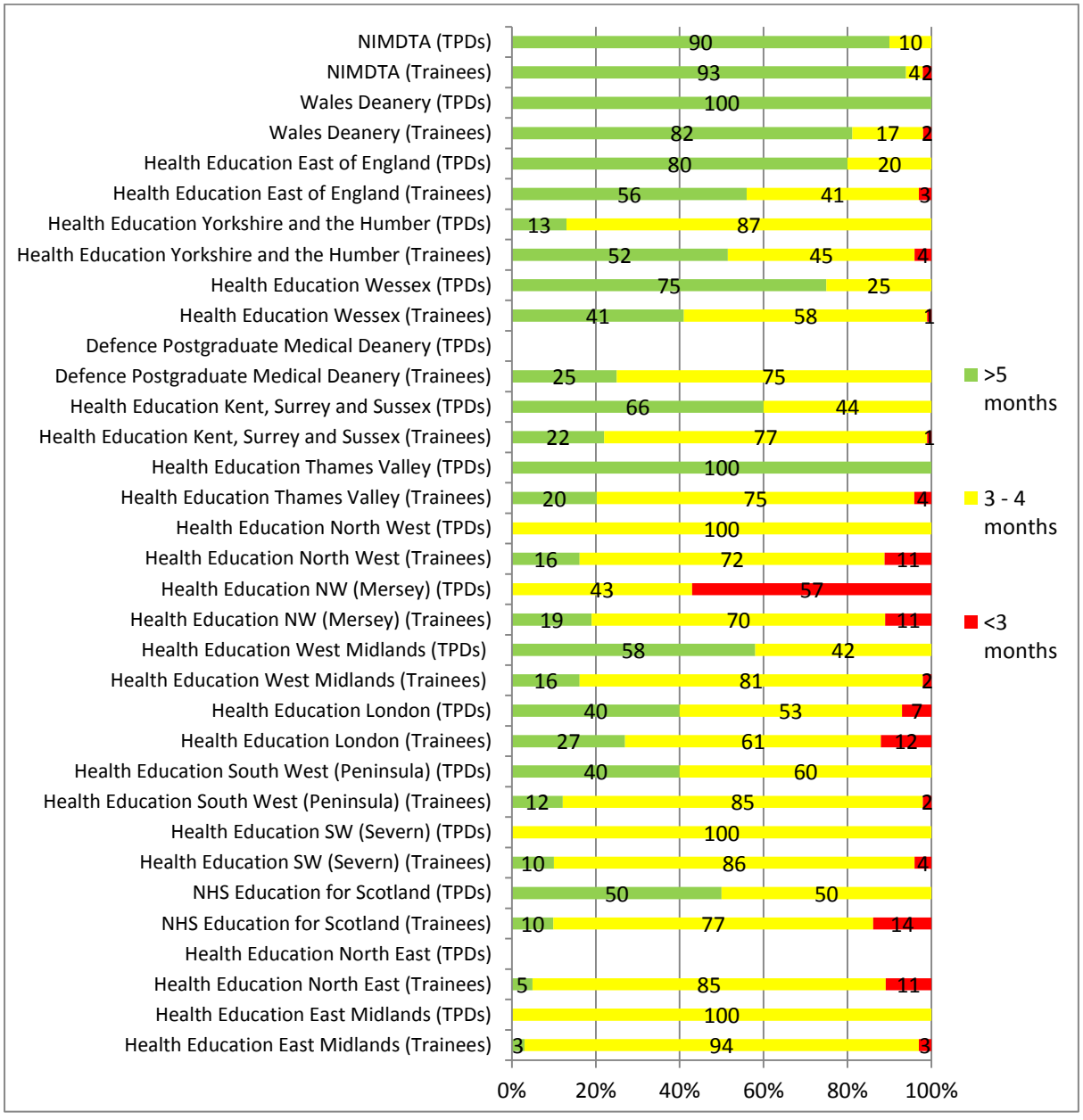
D2.1 35% of TPDs (25/72 TPDs) compared to 51% of all CMT trainees (1505/2947 trainees) said that CMTs were given at least six weeks' notice of their on-call rotas.

D2.1 Training Programme Director / College Tutor comments (20)

- Issues with HR centrally with very late release of info
- Generally about 4 weeks' notice - but aim for 6. It is difficult in August as we don't usually know how many trainees we will have until July
- Mostly good notice but some last minute changes do occur.
- This can vary between departments
- It's a shambles and getting worse
- Movement to an electronic roster has caused difficulty this year but previously they have had plenty of notice.
- depends on LEP
- Variable. The August one is terrible, despite reminders. Subsequent ones are a bit better
- However cover for absence often leads to changes required
- We try. Medical staffing offices generally find themselves very stretched and in a pickle. They seem to be genuinely under-resourced. It's not necessarily a question of the numbers employed, but about the calibre and the leadership in the dep't.
- Sometimes we meet 6 weeks
- This can vary in unforeseen circumstances
- 1st triplet 6 weeks but then they receive the rota for the whole 12 months
- Clinical Director has been informed of this requirement
- We have improved from a poor baseline and next rota already being worked on for December
- Ideally minimum of six weeks but due to Foundation changes and ever increasing number of vacancies and departmental changes to meet work pressures , rota plans suffer- do however have a dedicated individual to support rota but limited clinician engagement on Junior rota until recent redesign
- Although we usually have rota out within 6-week deadline (including those trainees allocated to date), I am aware some other hospitals would not.
- Varies significantly between Trusts. Some < 6 weeks, others > 12 weeks
- This is variable depending on the Trust. Generally it is more than 6 weeks.
- There has been a major reconfiguration of the GIM on-call rota at Worthing following the opening of the Emergency floor and this meant that the rota was not finalised until <6 weeks before trainees started in this particular round. Normally at least 6 weeks' notice is provided.

D2.2 Rotas cover minimum 4 months in length

Q. How many months does your rota normally cover?



D2.2 96% of TPDs (69/72 TPDs) compared to 93% of all CMT trainees (2739/2947 trainees) said that CMTs on-call rota covered more than three months in length.

D2.2 Training Programme Director / College Tutor comments (7)

- 4 months, though they rotate to a hospital with 6 month rotations. 4 months is barely long enough if there are nights and acute take within that but 6 month rotations does cut down the variety of specialties experienced.
- August - December December - July/August
- Covers the 4 months but usually issued late.
- New rota is for 12 months
- Dr Schomberg has done a fantastic job sorting the rota at FPH.
- In my hospital, cannot comment on other posts in the 18 months
- This comment based upon experience on my hospital site. I cannot comment on others.