NHS
Health Education England

Better Training Better Care (BTBC)
Pilot Site Evaluation Report

This report is designed to capture your pilot project in your own words. Each section should be completed in full, with appendices attached where necessary.

When completing the report, please adhere to the points below:

- Ensure that you complete each field provided.
- Ensure your answers are concise. Although there is no specific word count for each section, we are looking only for the relevant information to support wider adoption of your project. This report is intended to capture the fundamentals and the key outcomes of your project and should be succinct and easy to read, using plain English.
- Any toolkits, 'how to' guides or other resources that you feel are key to support the delivery of your project should be attached as appendices.

Please note that more detailed data and analysis of your project will be captured by our national evaluation partner Matrix Knowledge for them to independently assess.

Title

Please insert the title of your pilot and if applicable, a strapline to sum up the project in one sentence

Improving supervision in basic psychiatric training

Making psychiatric training posts relevant to all doctors in training by introducing standard work for training and supervision around core psychiatric skills

Introduction

The introduction should to summarise the background to the pilot intervention, what it set out to achieve and why.

1. Background

1.1 Rationale and drivers

- What was the rationale for choosing the project?
- What was the situation before the pilot was initiated?
- What were the local drivers / contextual factors?
- What problems were you trying to solve by implementing the project?

Tees, Esk & Wear Valleys NHSFT is a specialist mental health and learning disability trust serving 1.6 million people living in County Durham, the Tees Valley and North Yorkshire. With around 5700 staff, services are increasingly provided in the community (with outpatient clinics, liaison services, crisis services) but where in-patient admission is required we have a number of units including several new purpose-built hospitals.

The Trust provides basic psychiatric training in 2 deaneries across 2 core psychiatric training programmes, 4 GP training programmes and 3 foundation training programmes. We support over 100 training posts, the majority of which are for trainees in their early years (FY1 & FY2 doctors, CT1 psychiatric registrars and GP registrars). Most of these posts are well established but the FY1 posts were being newly introduced from August 2012. Training in psychiatry has been affected by redistribution of traditional roles and all our posts are compliant with the European Working Time Directive. Services have changed radically with consultants taking more specialist roles. The result is that training posts could become very fragmented if they were to provide a wide range of clinical experience. As such, we needed to give thought to continuing to provide high quality training in this changing environment.

Training in psychiatry has traditionally been delivered through indirect supervision and it is only since the introduction of workplace-based assessment (WPBA) that there has been regular observation of clinical practice. However this has increased concerns about supervision, assessment and feedback. The 2010 GMC visit to the Northern Deanery highlighted the national problem that WPBAs were not calibrated to the standard of the postgraduate clinical examination (the MRCPsych CASC) and there has continued to be uncertainty as to whether WPBA is a formative or summative assessment process. In our experience, where trainers were observing their trainees in the initial weeks, this was more about checking competency than using direct supervision and feedback as a training tool.

In our organisation, foundation doctors had reported that it took several weeks to settle into the job as the setting and expectations were very different from the acute hospital. Some had reported that they were not sure what they should be doing on a day to day basis and what was expected in terms of contribution to patient care. We were anticipating a large increase in the number of foundation posts, with a particular emphasis on the creation of new FY1 posts. We needed to make sure that our structure of induction and supervision could enable these new posts to deliver good quality training.

Another local problem was electronic records training. Complete electronic records were introduced to the Trust in 2008 using a software records system known as PARIS. Since the start, PARIS training had been a 2 day training with much the same training provided to all staff, irrespective of clinical role or IT experience. The training has persistently been criticised by training grade doctors as being too long, unhelpful and not timely (often being provided 2 weeks after starting at work).

We were also aware that settling into a new job is not just a problem in mental health services but is difficult for many doctors in training starting out in new specialties or services. Not only are there the learning needs relating to the training curriculum but also the systems and procedures specific to that specialty or service. We wanted to develop an approach to revising induction and supervision procedures which could be applied across the range of specialties and services in the NHS.

2. Approach and engagement

2.1 Project development

- How was the project developed?
- What was the approach taken for delivering the training intervention(s)?
- Who was involved in its development and implementation?
- What were the aims and objectives of the pilot?

Tees, Esk & Wear Valleys NHSFT has a highly developed quality improvement system (QIS), based on the Virginia Mason Production System, which in turn was modelled on Toyota lean production methods. The QIS has been used to improve administrative processes, develop clinical pathways and revise inpatient working practices. We wanted to use this methodology to plan the required changes to induction and supervision arrangements.

A QIS 3P event was planned for June 2012 with a view to the project starting with the new intake of junior doctors in August 2012. A 3P event or Production, Preparation, Process workshop is used when a process needs to be improved through complete reinvention and the targeted outcome cannot be reached through traditional incremental improvement.

The event was sponsored by the Director of Medical Education and led by a senior QIS certified leader. There were 12 participants: 4 consultant psychiatrists (covering adult and older person services and trainers of foundation, GP & psychiatric trainees), 2 senior trainees, 2 junior trainees, 2 modern matrons and 2 inpatient nurses.

4 planning meetings were over 4 weeks to prepare for the 3P event. This involved reviewing the targets for the event and developing some baseline metrics (understanding the tasks that junior doctors undertake and the expectations that senior doctors, clinical staff and patients have of them).

The 3P event developed three products:

1. Post configuration

The training posts in the Tees locality were reconfigured such that all foundation doctor posts were placed at Roseberry Park hospital (the main inpatient base), all GP registrar posts were placed with adult or elderly community teams and all CT1 core psychiatry registrar posts were placed in acute settings (adult inpatients, adult crisis services, older persons inpatients). Each doctor would have a “home” clinical team where the greater part of their clinical work would be carried out to enable maximum benefit from team working.

2. Induction

A new model of induction for the Tees locality was devised. This took the form of workplace based induction from day 1 with a 3 hour electronic records training within the first 2 days. That the doctor was new to psychiatry would be designated by the doctor wearing a different coloured lanyard with their identity badge. Priority would be placed on workplace processes and the core psychiatric skills. These skills were defined as: information gathering (history

taking, mental state examination, risk assessment); information processing (record keeping, interpreting investigations, case formulation); communicating information (oral & written communication, negotiating a management plan); prescribing (safe prescribing, rapid tranquillisation); using the Mental Health Act. An individual or group training session with a clinical pharmacist on standards for prescribing was scheduled for week 2. Induction into the on-call system was scheduled for the end of week 2, prior to any new doctor undertaking on-call work. Other mandatory, but not priority training requirements were postponed to after the first 4 weeks in the job.

3. Supervision

A supervision planning meeting was scheduled with the clinical supervisor on day 4 of the placement. This meeting would review progress made in the initial induction phase and plan the opportunities for direct supervision of clinical practice in the initial weeks. Depending on the confidence and competence of the doctor, supervision would move from direct to immediate indirect to reflective indirect supervision over the course of the initial weeks. Constructive feedback on directly supervised clinical encounters would be provided immediately by the senior doctor, with feedback from the patient included where possible. After the first 4 weeks, supervision would revert to the traditional psychiatric model of one hour of protected time per week.

The aims of the project were defined as follows:

- Make psychiatric training posts relevant to all doctors in training
- Introduce standard work for training and supervision around core medical tasks
- Improve productivity of training grade doctors new to psychiatry

2.2 Engagement

- Who did you need to engage in the pilot – for example: trainees, trainers, consultants, patients, executive Board members?
- What was the level of lay and patient involvement?
- Did you get support from an academic partner to develop the evaluation and outcome measures?

The staff whose engagement was critical to the success of the project were the trainees, the clinical supervisors and the clinical team managers.

Trainees were notified in advance of their placement that there would be some changes to the delivery of induction and supervision. On their first day in the job they received information about the project and their participation in it. They were asked to complete baseline measures. None declined to participate in the project or complete the measures.

Trainers were informed through briefings at the Trustwide Senior Medical Staff Committee and local consultants meetings in June and July 2012 and through a BTBC e-mail briefing. Those consultants in the Teesside locality who were clinical supervisors of foundation doctors, GP registrars and CT1 psychiatry registrars were invited to a training day in formative assessment and giving feedback in July 2012. All but two of the clinical supervisors attended one of the two training days provided. The other two consultants received an individual briefing along with the training materials.

At the 3P event, the need to engage with clinical team managers emerged. As a result the modern matrons in adult and old persons mental health services were tasked with briefing their colleagues about the project and the role that team managers would be expected to take.

We did not invite patients or lay people to the 3P event to plan the project on the basis of limiting the invites to those we felt were absolutely necessary. A number of patients were asked their opinions about the role of junior doctors during the planning of the 3P event.

The project was discussed and agreed by the senior clinical forum within the Trust (the clinical leaders and operational directors monthly meeting) and gained the support of the Chief Executive and Medical Director. Regular reports were provided by the project lead to the Medical Director and the Chief Operating Officer.

The Trust Medical Education Department has an established relationship with the Durham University medical education research group and they were the obvious candidate to act as an academic partner. They were not involved in the planning of the project but were invited to steering group meetings from October 2012 when the overall approach to evaluation was reviewed.

2.3 Project management and governance

- How was the project managed and implemented? i.e. what governance, project management structures and processes were put in place?

At the start, a BTBC project steering group was set up, comprising the project lead (the outgoing Director of Medical Education), the incoming Director of Medical Education, the Tees clinical director for adult mental health, the Tees clinical director for mental health for older persons, a senior trainee representative (a psychiatric senior registrar) and a core trainee representative (a psychiatric core registrar) and the medical education and development manager. Hence the steering group had senior representation from both the medical education department and the relevant clinical services. Progress was reported to the Trust's monthly medical directorate management meeting, chaired by the Trust's Medical Director. There were 12 steering group meetings between April 2012 and September 2013. From May 2013, additional members were invited to the steering group from the medical education faculty to consider the evaluation, dissemination and roll out plans.

Day to day management of the project fell to the project lead assisted by clinical and administrative staff. 3 senior registrars provided support at various stages of the project and staff from the medical development team provided administrative support.

3. Resources

3.1 Funding

- What funding did you bid for as part of your application and how much were you awarded?
- What were the overall financial resources required to deliver your project? Please include the amount of trust funding required in addition to the BTBC funding.
- What was the final budget amount at the end of your project? (Please include the detailed funding schedule as an appendix.)

We bid for funding to support the implementation and evaluation of the project rather than any clinical time costs which was the element of the project which had to be sustainable. We were awarded £35,000 broken down as follows:

0.5 WTE senior registrar to support implementation and evaluation	£25,000
Consultant time for training in new model of supervision	£5,000
Equipment and resources (software, training resources, consumables)	£5,000

It is not possible to specify the overall financial resources to deliver the project as so much of it was about the day to day clinical supervision of junior doctors in the early weeks of their post and we did not ask consultants to keep a record of the amount of time they devoted to that supervision work. The costs reported below do not include the medical staff time for clinical supervision but show the costs of planning and implementing the project:

0.1 WTE project lead (consultant psychiatrist)	£14,250
0.2 WTE senior registrar	£11,790
0.1 WTE clerical officer	£2,065
Training events for clinical supervisors	£2,175
Quality improvement event (planning meetings, event itself etc)	£6,150
Medical induction sessions (in addition to usual)	£1,200
Equipment (lanyards, scanner, software, consumables)	£3,500
Total	**£41,130**

3.2 Staffing

- What were the human resources required to deliver your project?

The estimated time of staff input to the project was as follows:

Project lead	0.1 WTE consultant psychiatrist for 18 months
Project clinical support	0.4 WTE senior registrar for 12 months
Project administration	0.1 WTE clerical officer for 18 months

3.3 Other key resources

- Did you require any IT equipment or other types of equipment / specialist input?
- Did you require any specialist medical devices or materials?

The equipment required for the project was minimal. We had to purchase differently coloured lanyards for the doctors to wear. A scanner was purchased so that trainees upload paper copies of *Observed Encounter Reports* into their electronic portfolios. We also bought a statistical software package (SPSS) to facilitate data analysis.

4. Achievements and outcomes

4.1 Overall achievements and critical success factors

- What have been your greatest achievements and why?
- What have been the critical success factors for enabling these achievements?

The most significant achievement was the increase in the amount of direct supervision that doctors new to psychiatry received in their first 4 weeks in post. This was the primary aim of the project and it was achieved.

However there were other successes which were also important. The level of clinical supervisor support and enthusiasm for the new approach was greater than anticipated. There was no active resistance from any clinical supervisors in the planning and implementation phases of the project and a large proportion of them made changes to their working practices to enable the project to work. In addition, there has been a clear impression that the delivery of care on acute inpatient wards has improved with more "hands on" clinical work from junior doctors.

The piloting of changes in IT and electronic records training has resulted in new arrangements for this training being rolled out across the Trust. At the end of this there will be a 50% reduction in time spent in training but with an improvement in electronic records competency.

4.2 Delivered outcomes

What outcomes has the project delivered for the following:

- For trainees
- For trainers
- For patients
- Across the wider multidisciplinary team
- That provide value for money

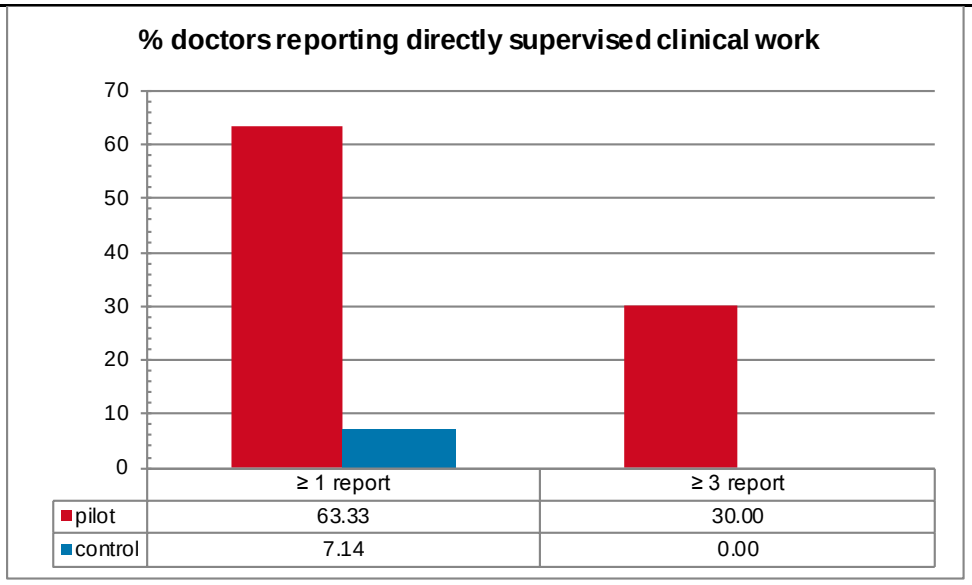
Please provide headline key findings with possibly a bar, line or pie chart to summarise the findings, rather than detailed analysis and tables. Matrix Knowledge will ensure that they capture the detailed data as part of their evaluation.

For trainees

The key outcomes for trainees were: amount of direct supervision provided, amount of patient feedback sought, clinical confidence, psychological well-being, quality of induction, quality of training post.

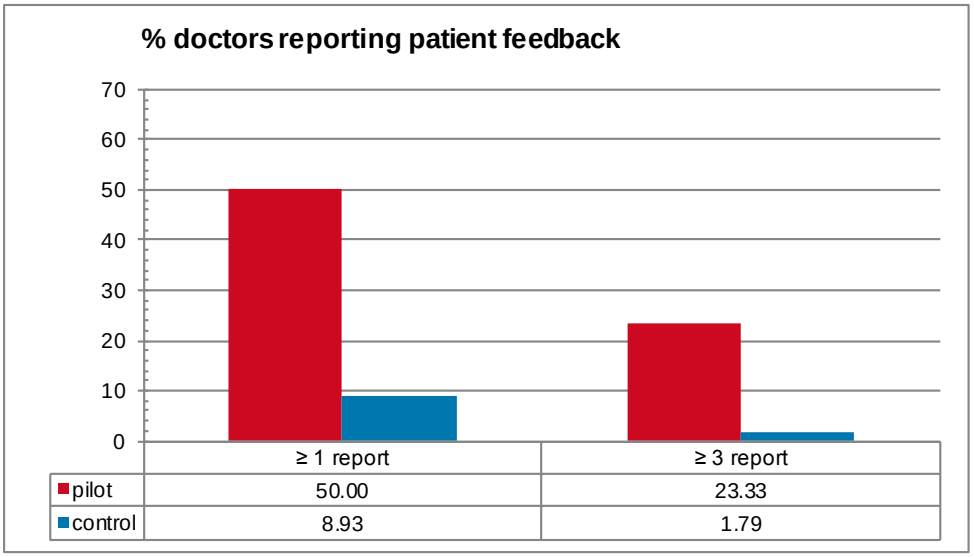
Direct supervision

This was measured by asking doctors in both pilot and control areas to submit *Observed Encounter Reports* when they were directly supervised by a senior doctor undertaking a clinical task with a patient. Doctors in the pilot area reported significant more direct supervision in the first 4 weeks of the post. The chart shows the proportions of doctors in the pilot and control areas reporting at least one and at least three directly supervised clinical encounters.



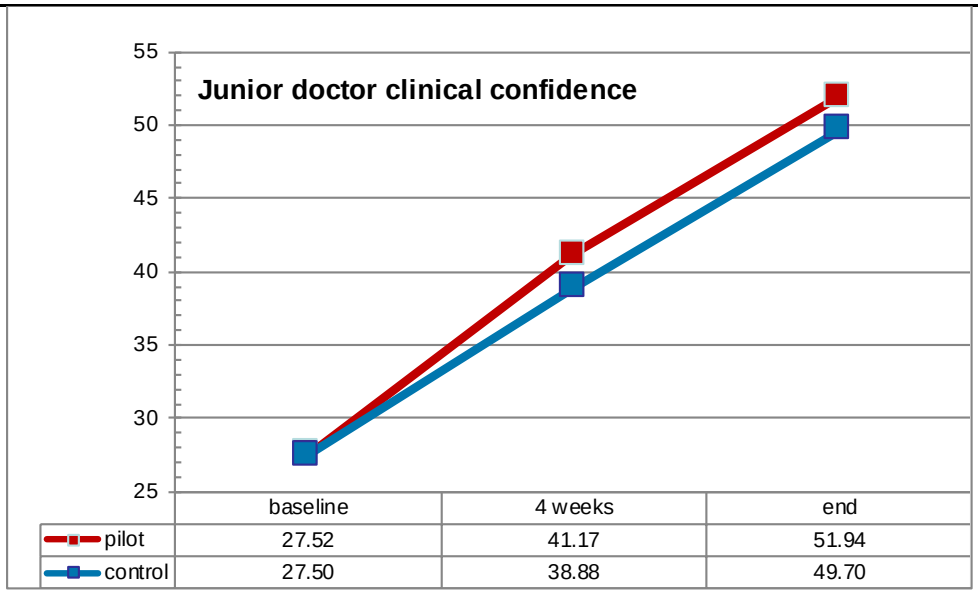
Patient feedback

This was measured by asking doctors in both pilot and control areas to submit *Patient and Carer Experience Questionnaires* when they sought feedback from a patient after an observed clinical encounter. Doctors in the pilot are reported significantly more patient feedback. The chart shows the proportions of doctors in the pilot and control areas submitting at least one and at least three reports of patient feedback.



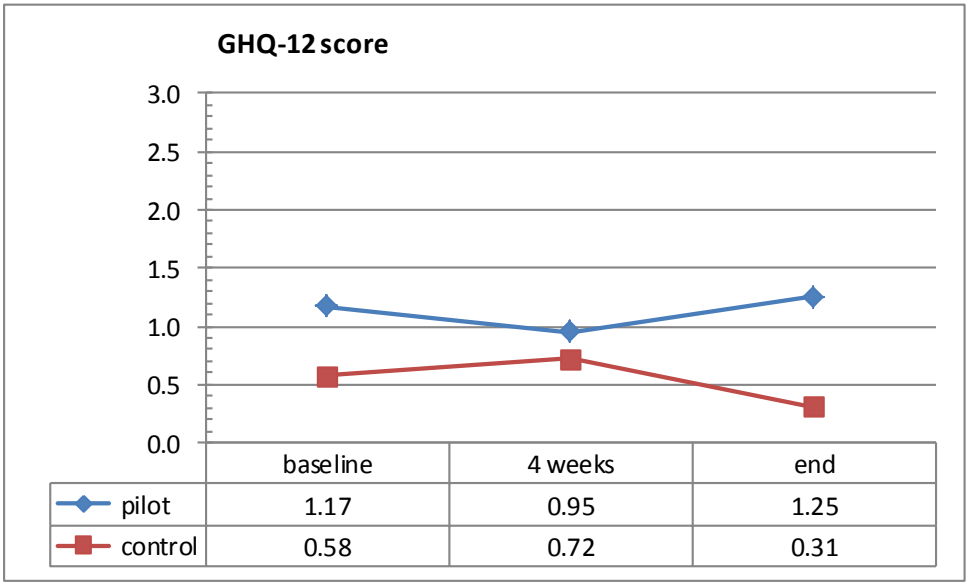
Clinical confidence

This was measured using a 12-item questionnaire assessing confidence in undertaking core psychiatric tasks quickly and competently on a five point scale, for example, undertaking a risk assessment and management plan; initiating drug treatment for common psychiatric conditions (range 12 – 60). Clinical confidence was measured at baseline, 4 weeks and at end of post and the chart shows the results from doctors who completed the measure at all three time points. The difference between the pilot and control group is not significant.



Psychological well-being

Starting a new job in a new specialty is an anxiety-provoking experience and we wanted to assess the doctors' level of psychological distress. We used the *General Health Questionnaire (GHQ-12)* at baseline, 4 weeks and at end of post. There was no significant difference between the pilot and control group doctors.



Quality of induction

Formal feedback from trainees about their experience of induction, supervision, training and clinical experience was only sought from the final cohort of doctors (starters in February and April 2013). This was because we wanted to develop a tool which would be used on a regular basis in the future by the training programmes and it needed their approval. Satisfaction with various aspects of the post was measured on a 5 point scale where 1 = unsatisfactory and 5 = excellent). For this group of doctors the results for satisfaction with induction were: pilot group, n = 11, mean score = 4.36; control group, n = 23, mean score = 3.61; t = 2.06, d.f. = 32, P = 0.05.

Comments from the pilot group included: "very in depth", "very good and organised", "good

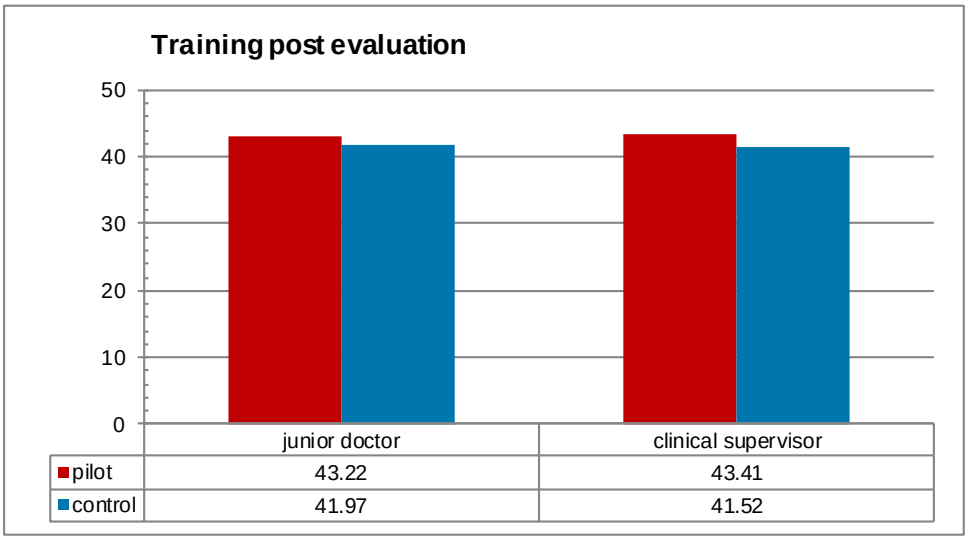
thorough induction programme"

Comments from the control group included: "relevant information lost amongst less pertinent information", "needs more focus", "very intensive but worthwhile", "overwhelming, repetitious", "PARIS induction not specific to doctors", "too many e-learnings"

Quality of training post

We asked all trainees and their clinical supervisors to complete a 10-item questionnaire on the quality of the training post which covered issues pertinent to the BTBC project. Respondents were asked to rate agreement with statements on a five point scale so the range of possible scores was 10 - 50.

The chart shows the results from junior doctors and their clinical supervisors in both pilot and control areas. Nearly all posts were highly rated by both trainees and their supervisors and the differences between the pilot and control area were not statistically significant.



	junior doctor	clinical supervisor
pilot	43.22	43.41
control	41.97	41.52

For trainers

The key outcome for trainers was whether they were able to provide the amount of clinical supervision required within their regular working week. We also wanted to know their assessment of whether the training post was able to deliver the required training.

We surveyed the 26 clinical supervisors who participated at the end of the project. 8 responded and they all agreed that the aims of the project had been met. There was a consensus that the project had resulted in a more standardised approach to supervision and that patient care had benefited as a result.

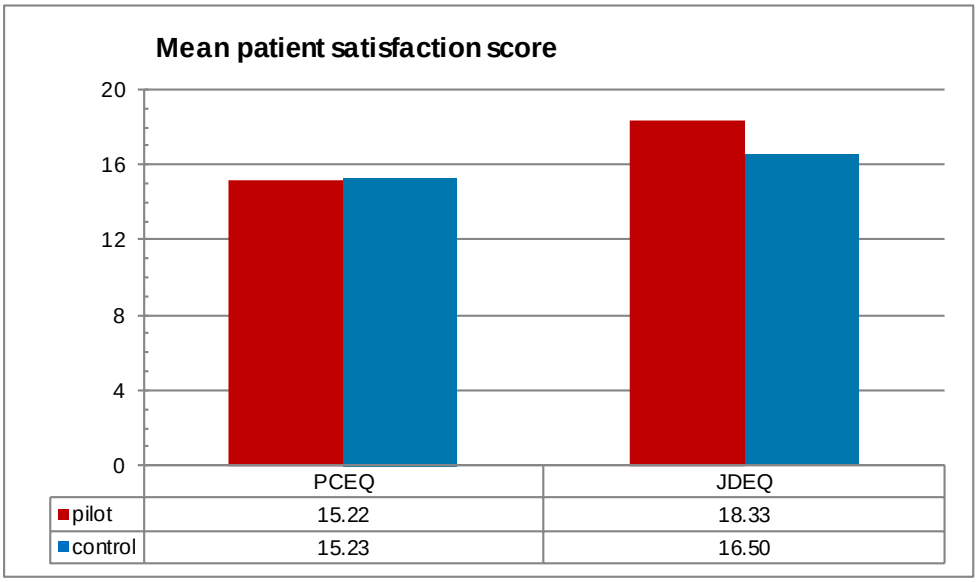
All clinical supervisors in both pilot and control areas were invited to complete the training post evaluation report. The results of this are shown above alongside the junior doctor responses.

For patients

The key outcome for patients was improved satisfaction with care provided by junior doctors. We also wanted to know if junior doctors were spending more time with patients in the initial weeks of the post and whether they were making fewer prescribing errors.

We measured patient satisfaction in two ways: first through feedback reports following observed clinical encounters (using the *Patient and Carer Experience Questionnaire)* and second through feedback reports following a completed episode of care (using the *Junior*

Doctor Evaluation Questionnaire). The PCEQ is a 4-item questionnaire rated on a 4 point scale (range 4 – 16) and the JDEQ is a 5-item questionnaire rated on a 4 point scale (range 4 – 20). Doctors were asked to collect patient feedback opportunistically. The chart compares the mean patient satisfaction scores on the PCEQ and the JDEQ between the pilot and control areas. Any differences are not statistically significant.



	PCEQ	JDEQ
pilot	15.22	18.33
control	15.23	16.50

With respect to time spent with patients, we examined the electronic case records of patients admitted to acute adult wards in April 2013, the first month of the post for the final cohort of foundation doctors. This data has proved difficult to interpret. The amount of time doctors spent with patients was determined through recorded clinical contacts which may not have been an accurate account of work done. The final cohort of doctors had the fewest returns of *Observed Encounter Reports* and it was clear from the audit that there was no important difference between the pilot and control area in the quantity or quality of recorded clinical contacts by inpatient based foundation doctors.

Our efforts to determine whether the project resulted in fewer prescribing errors in the pilot area failed. Doctors in the pilot area received individual or group support sessions with a clinical pharmacist in the initial weeks to ensure Trust standards of prescribing were met. However, data on prescribing errors was only available by ward and could not be used to report errors by doctors individually. We do not know if the doctors who got the pharmacist support had a higher standard of prescribing.

Across the wider MDT

We asked clinical team managers (from wards and community teams) for teams where junior doctors had participated in the project to provide feedback on the impact of the project in their area. We received responses from 10 members of staff. They were overwhelmingly positive about the impact of the project on the work of junior doctors in their team and the overall impact on team working.

Informal feedback from non-medical staff indicated that having new and inexperienced doctors wear a green rather than a blue lanyard for their identity badge, helped staff manage their interactions with medical staff better.

That provide value for money

IT and electronic records training

One of the aims of the project was to make induction more effective and one of the concerns had been the way IT and electronic records training was delivered. The training lasted 2 days and could not be guaranteed to be provided in the first few days of the job, while staff cannot use the records system until training is completed. This meant that doctors were at work for sometimes 2 weeks without being able to access patient's records. In the pilot project, this training was delivered in 3 hours on day one or day two of the job.

We measured the quality of the IT and electronic records induction from doctors who started in February and April 2013. The doctors in the pilot area (n = 10) received the tailored 3 hour training while the doctors in the control are (n = 22) received the standard 2 day training. The survey asked the doctors how confident they were in various aspects of the electronic records system. They were also asked how long they thought the training needed to be and when they thought the training should be undertaken. There were 12 questions to be rated on a 5-point scale, giving a total score ranging between 0 and 60. 20 doctors completed the survey (brief training, n = 8 (80%), mean score = 24.67; standard training, n = 12 (63%), mean score = 24.63). The most common response on preferred length of the training was 1 day (n = 11, 55%). However a significant minority thought training could be delivered in 1 -3 hours (n = 6, 30%). The most common response on preferred timing of the training was in the first three days of the job (n = 16, 80%). IT and electronic records training was poorly evaluated by new doctors, irrespective of the training they received. There was no evidence to suggest that the standard 2 day training offers any advantage over the brief 3 hour training.

5. Experienced challenges

List the challenges you experienced, why you experienced them and what steps you took to overcome them, or if not, why not? It is important to capture any challenges or issues that made an impact on progress - irrelevant of how small.

The first challenge was to implement the project at such short notice. Planning started in April 2012 once the bid had been successful and we were lucky to secure a time slot with the Trust's quality improvement team to hold the QI event in June. However this meant we had only 6 weeks to revise job descriptions and prepare for the first cohort of doctors arriving in August 2012. The principal obstacle was obtaining approval for amendments to the job descriptions for 4 GP registrars from the GP training programme. This was because any change to location of a post (and three of the posts had the main clinical base changed, although most of the work was unchanged) required approval from the GMC.

The implementation of closer supervision in the initial weeks was problematic in some posts in August 2012 because the clinical supervisor took their annual leave during that month. Although the Trust had a system for providing supervision in the absence of a clinical supervisor, this was not sufficient to meet the standards set for the project. Unfortunately this is an inevitable consequence of training grade doctors starting posts during school holidays.

Early feedback from junior doctors and clinical supervisors in August and September 2012 showed that the standards for supervision were felt to be too prescriptive. Also there was some misinterpretation of the guidance given – so for example, some wards stopped new doctors from undertaking routine work as they felt the doctors first needed to demonstrate their competence. As a consequence of this feedback, less prescriptive guidance was given to junior doctors and their clinical supervisors in the subsequent cohorts and it was emphasised that the need for closer supervision was not about competency assessment.

One of the challenges in evaluating the project was collecting evaluation reports from junior doctors. In particular they commented that submitting the supervision reports was a

bureaucratic exercise which for some duplicated the work they had to do for their training portfolio. As a result, the reported level of direct supervision is almost certainly an underestimate of the actual level of direct supervision provided.

The method of gathering patient feedback did not work well. Doctors felt awkward about seeking written feedback at the time of directly supervised encounters and the number of reports submitted was quite low. At the same time, seeking feedback at the completion of an episode of care was also problematic as patients would often be asked to give overall feedback on the service at the same time.

Some of the statistically insignificant results could be type 2 errors. The overall sample size (pilot area, n = 36; control area, n = 69) was good enough to detect quite small differences in the clinical confidence and training post evaluation outcomes. However, there was a high level of attrition in response, particularly in the control area. This could have been anticipated given the design of the project. Control area participants did not have to "opt in" and give any commitment to the project, and any heavy handedness in encouraging completion of evaluation reports could have been counterproductive.

6. Lessons learnt and recommendations

6.1 Lessons learnt

- Other than the above challenges, what have you learnt through your experience of designing and implementing the project?
- Were there additional benefits realised that were not originally identified at the start of the project? E.g. knock-on impacts to other members of staff who were originally not targeted; greater collaboration across teams; and/or a financial gain which was not originally in the plan.
- If you were to undertake a similar project, what would you do differently?

The principal finding was that increased levels of direct supervision can be provided to junior doctors when they start in a new post and that this has a positive effect on the working of the clinical team. Clinical supervisors reported that what had previously been sporadic practice was now standard practice.

We have been able to show that psychiatric training posts can be made relevant to all doctors in training as demonstrated by qualitative feedback from clinical supervisors and non-medical staff. The evaluation showed that trainers and non-medical staff believe that doctors new to psychiatry are now more quickly prepared for practice and that their contribution to service delivery has improved.

However there is a significant amount work required to ensure that this happens. Quality improvement methods which use the staff from all grades and disciplines to plan changes are a good mechanism for achieving change as long as there is organisational commitment to this approach.

In planning the project we quickly became aware that the postgraduate medical curricula (in this case foundation, general practice and core psychiatry) are not sufficient for designing training posts that will work. This is because they cannot account for all the circumstances that apply in the delivery of patient care in individual units. As a result, junior doctor job descriptions need to describe not only the intended learning outcomes, but also how the clinical duties of the post will enable those outcomes to be achieved. Our experience is that job descriptions often do not describe the clinical duties well enough to help junior doctors understand what their role is on a day to day basis.

The change in the foundation programme from workplace based assessments to supervised learning events has helped to make it explicit that workplace based assessment is a formative rather than a summative process. However, it is clear to us that GP and psychiatry registrars continue to view workplace based assessment as a quasi-summative process and this undermines efforts to document feedback on direct supervision in their portfolios.

Postgraduate medical induction has a crucial role in preparing a junior doctor for a clinical placement. For this to be effective there has to be a careful balance between developing the learning plan with the clinical supervisor, understanding how to deliver the specific duties of the post, and general Trust mandatory requirements.

6.2 Recommendations – project enablers

What recommendations can you provide to other NHS trusts who may want to adopt your project? Please think about the critical 'enablers' that need to be in place to ensure the success of the project.

There were 3 core elements to the project: post configuration, induction and supervision.

Post configuration is about ensuring that the training posts are doable, provide relevant experience, and enable a meaningful contribution to patient care with a single clinical supervisor having responsibility for the post working as a whole. As services regularly change, this is a continuous challenge. Trust medical education departments need to take the lead here and have the authority within the Trust to plan and deliver change. However, this can only be done in close co-operation with clinical services.

Induction sets the tone for the job and is therefore of crucial importance. It needs to be understood that it is the shared responsibility of the clinical supervisor, the clinical team manager and the Trust medical education department. Induction needs to focus on the immediate service and training commitments which the doctors face and can easily be undermined by ill thought out mandatory training requirements. Trainees should be advised when to complete those elements of mandatory training which are not an immediate priority at the start of the post.

For supervision and feedback to be effective, clinical supervisors and junior doctors need to know what the core clinical skills to be developed at the start of the post. Where the training curriculum is not sufficiently explicit in this regard, the Trust should provide guidance according to specialty. This would generally be necessary for foundation and hospital-based general practice training posts. There needs to be a commitment from the employer to training and this means that clinical supervisors will have training in formative assessment and giving effective feedback. Direct supervision of and feedback on communication skills would require that clinical supervisors have a level of competency in communication skills themselves. Postgraduate Schools and their training programmes should provide guidance to trainers and trainees on documenting formative assessment. This could be by greater use of WPBA tools (used explicitly as a formative tool) or by recording reflective notes in the training portfolio.

7. Sustainability and adoptability

You should be able to use the information provided in your project closure report as a basis for completing this section.

- What plans are in place to continue the project within your trust – please include details of wider trust roll-out and/or spread to other specialties?
- How is the project being managed and by who?

- What are the governance arrangements in place?

The outcome of the pilot project was discussed at the Trust's biannual medical education faculty development day in October 2013. There was discussion about why the secondary outcomes of the project were not achieved given the strength of effect with respect to the primary outcome. In addition, the complexity involved in reconfiguring training posts in other localities was highlighted. However, the new standards for induction and supervision will be embedded within normal clinical and educational practice within the pilot area with a view to rolling this out to the rest of the Trust over the coming year. In particular, Trustwide medical induction will be revised followed a quality improvement event in November 2013, with a view to implementing the changes with the February 2014 cohort of new doctors.

Within the Trust, responsibility for roll out within the Trust passes to Dr Jim Boylan, Director of Medical Education. The standards for induction and supervision across the Trust will monitored within the Trust's medical education governance arrangements and reported to the relevant LETBs (Health Education North East and Health Education Yorkshire and the Humber).

8. Feedback and testimonials

- Please use this section to capture the feedback and testimonials you have received throughout the pilot project (where consent is given). This will be used for the final case study to support the engagement with and adoption by other trusts. You may include this as an appendix, weave the comments throughout the report or insert them in this section. Please state the title of the person concerned.

- Please aim to include a good selection of quotes from trainers, trainees, other members of the MDT, the Medical or Education Director and CEO if possible.

TEWV Trust Director of Medical Education, Dr Jim Boylan:

"The Better Training Better Care pilot to support doctors new to Psychiatry has been very useful in shaping our strategic plans to assess and accommodate their training needs in the vital first few weeks. It has given the impetus and focus to develop more structure and clarity about the content of the programme with their individual trainers and we have already made some important changes to our trust-wide and locality induction programmes. We have developed templates and structures for clinical skills assessment and now delivered clinical skills assessment training to almost 60 Consultant Trainers and Senior Registrars across our trust. We continue to review this process and have a further QI event on the induction programme in early November with the objective of rolling out the changes across our trust by February 2014."

TEWV Trust Senior Postgraduate Tutor (Teesside), Dr Raj Kumar:

"The BTBC is a project with high face validity which is difficult to contradict. The amount and quality of direct supervision for beginners in speciality postings has to deliver better training and care. While it is easy to capture the significant difference in primary outcome, I think the secondary outcomes are difficult to measure unless assessed over a period time (which may require a longer period of monitoring this cohort). With regards to configuration of posts, there may be some anxiety about potential implications in services, if rolled out. However, there is nothing stopping implementing the principles of BTBC in whatever posts the trainees are allocated to in other areas. It would certainly be better for a GP trainee to

have increased supervision in the first month, than going to clinics in a specialist service at the very beginning.

TEWV Trust Foundation and GP tutor (Teesside), Dr Baxi Sinha:

"I do feel that BTBC initiative has been a worthwhile improvement and needs to be rolled out to the entire organisation and beyond."

Comments from junior doctors:

"induction was very well organised and useful"

"feedback was constructive and encouraging"

"thorough and useful start to the programme"

"highly supported in psychiatry as a non-psychiatry trainee"

Comments from clinical supervisors:

"I think the project considered the needs of the trainees, much better than the previous system of training"

"high levels of supervision in the initial weeks is standard now rather than the variable levels in the past"

"I do feel that trainees feel more supported. Secondly, their contribution to service delivery has improved"

"I think, the project can be rolled out effectively, supervisors must buy into the process"

Comments from non-medical staff:

"they seem better prepared for clinical practice"

"medical staff spend more time with patients"

"general team working seems to have improved"

"they are able to undertake all aspects of the role quicker"

"junior doctors still take time to develop into the post"

Appendices

If you have developed any toolkits, 'how to' guides or other resources that you would like to share, please include these as an appendices to the report.