

Enhancing Supervision for Postgraduate Doctors in Training



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Executive summary

Headlines

HEE's Supervision Guidance provides:

- A cross-ALB commitment to the importance of all forms of Supervision in the context of patient and trainee safety;
- Formal recognition and valuing of Workplace Supervision, as a separate entity to Clinical Supervision and Educational Supervision;
- Lightening the load for Educational and Clinical Supervisors by championing the role of Workplace Supervision;
- Support for enhanced Multiprofessional Working.

What we heard

As part of our ongoing work on Enhancing Junior Doctors Working lives, HEE's quality reviews, the Staff and Learner Mental Health and Wellbeing commission, the Review of training and the support for learners and the review of foundation training, we have heard repeatedly about issues with trainee supervision.

We heard concerns from trainees and trainers across the system that the quality and provision of Educational and Clinical Supervision was inconsistent and that this could negatively impact on patient safety and the training experience for doctors, leading to burnout and recruitment and retention issues. There was a lack of clarity around how to improve supervision when issues had been raised, and which organisations locally and nationally held responsibility for ensuring appropriate supervision was in place.

We also heard that there was confusion around the definition of the various supervisory roles, and that a large amount of extremely valuable supervision – Workplace Supervision - is provided by members of the multi-professional team, but currently goes unrecognised.

What we did

- The working groups consulted different groups of doctors in training, medical educators and trust representatives, reviewed the evidence collected through HEE reviews, collated good practice examples from across the country from employers, postgraduate specialty schools, Directors of Medical Education (DMEs) and doctors in training.
- Engaged with DMEs in Trusts, through the National Association of Clinical Tutors (NACT), to clarify the roles and responsibilities of the different individuals providing supervision
- Worked collaboratively with CQC and NHSE&I to produce consensus statements setting out the importance of supervision from a patient safety and trainee safety point of view. We formalised each organisation's commitment to ensuring high quality supervision.
- Supported the CQC in ensuring patient and trainee safety is maintained; we produced a video for CQC lay inspectors explaining the purpose of supervision of doctors in training, how it relates to the Well Led Framework and how inspectors can judge whether a department provides good supervision
- Increased understanding about supervision, to improve standards. We produced an animation aimed at doctors in training and trainers (with input from experts in the field of supervision) which clearly defines the roles and responsibilities of each type of supervisor in postgraduate medical education.
- Formalised the Workplace Supervisor role and highlighted its importance within multiprofessional team working. This is the first time this role has been formally identified and acknowledged.
- Produced guidance for doctors in training and trainers on getting the most out of a supervisor-supervisee relationship (in the form of a handbook and an animated video)
- Produced 'Standards In Supervision' - a quick reference guide for departments to benchmark how they are performing in terms of the supervision they provide for trainees
- Initiated parallel work to help define supervision for ACPs and Dental trainees to inform HEE's supervision toolkit



Background

Introduction

The Enhancing Junior Doctors' Working Lives (EJDWL) and Annual Review of Competency Progression (ARCP) programmes have engaged with a large number of doctors in training and educators. Several issues surrounding supervision were highlighted repeatedly.

Firstly, we heard that there was inconsistency and confusion surrounding the various roles providing supervision to doctors in training, including how these roles interlink, and how they vary depending on specialty and the nature of the learning environment. Doctors in training have told us that at times they are unsure where they should turn for support and unclear on who is responsible for their training, development and clinical experience.

Increasing service pressures have placed huge demands upon those involved in supervisory roles, especially consultants who often hold dual roles as Educational and Named Clinical Supervisors. Again, this can leave doctors in training feeling that they are not adequately supported in terms of their development. Parallel to this, other doctors (especially Staff and Associate Specialist doctors) and healthcare professionals (including those engaged in Advanced Clinical Practice) tell us that they are not utilised effectively in the supervisory process.



Health Education England is responsible for monitoring and improving the quality of the clinical learning environment through the HEE Quality Framework. Within this, provider organisations are expected to ensure that all educational supervisors receive 0.25 Planned Activities (PA's) rostered per week for each trainee they support, equivalent to 1 hour per week per trainee. This time allocation covers face to face meetings, ARCP requirements, administrative and CPD time. Increasingly, trainees and educators suggest that this protected time is not always being provided. There are also expectations on time for supervision in GP specialty training where SPAs do not apply.

Finally, we have heard that some supervisors feel they receive insufficient support to develop as educators, which leaves them feeling they are not adequately equipped to support doctors in training. In certain areas there is confusion as to the appointment, development and appraisal processes for those in educational and clinical supervisor roles.

High quality supervision is vital to the development of doctors in training regardless of stage in the training pathway or specialty. This is recognised across the system, as it directly relates to the patient safety and the safety of doctors in training as well as recruitment and retention. Key partners including CQC and NHSE&I have highlighted their commitment to enhancing the supervision provided to doctors in training, and their statements on this are a core element of this guidance document.

Parallel to the Enhancing Supervision workstream that has resulted in this report, there are substantial programmes of HEE work that also reference the need to improve supervision. These include the review of the Enhancing training and the support for learners^[2], the Foundation Programme Review^[3], and the NHS Staff and Learners' Mental Health and Wellbeing Commission^[4], which have resulted in a number of recommendations related to supervision.

Importance of supervision

The link between high quality education and training and improved patient safety is well documented. The experience of postgraduate trainees and students can be a good barometer for potential patient safety and service fragility issues.^[1]

This guidance is aimed at individuals who are providing and receiving supervision in the workplace, and Departmental Education Leads and Directors of Medical Education who are overseeing supervision processes within their department or Trust.

Supervisors within the context of this document may be consultants, SAS doctors, senior nursing staff and others (dependent on type of supervision and level of training of supervisee). Supervisees within the context of this document are postgraduate doctors in training. **There are parts of this guidance that will be relevant to supervision in primary care and developing supervision models amongst the growing Advanced Clinical Practitioner workforce. There is an accompanying HEE document that details the supervision requirements of trainee and qualified Advanced Clinical Practitioners.**

In the context of anticipated multi-professional workforce transformation, those engaged in the supervision or practice education of colleagues holding a different registration will need consider both overarching common principles of good supervision as well as registration-specific requirements.

What is Supervision?

Good Supervision has 3 main functions:

Normative: ensuring that the supervisee can provide high quality patient care

Formative: learning in the workplace occurs through good supervision, with high quality timely feedback to the supervisee from a senior professional fundamental to this learning

Restorative: good supervision enhances the wellbeing of the supervisee ^[5]

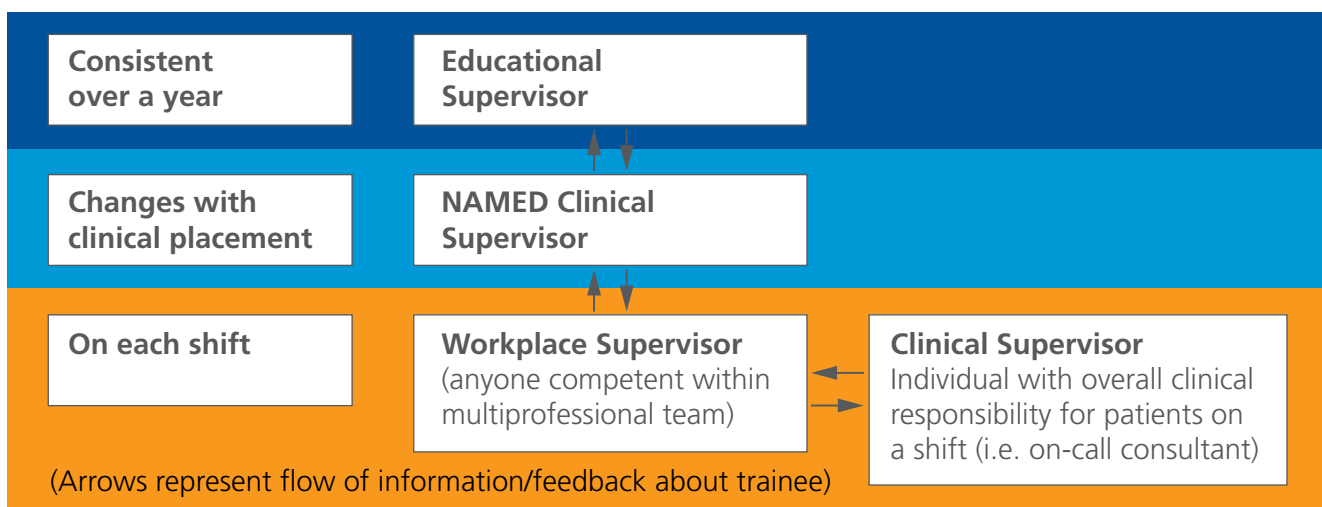
Purpose of Supervision:

1. Enabling the progression of healthcare professionals along a training and/or professional development pathway with respect to acquisition of knowledge, clinical skills and competencies
2. Enhancement of general (clinical) and professional skills and attitudes
3. Ensuring both good patient experience and safety

Definitions

In postgraduate medical education, we have come to see that there are three levels of supervision, and four distinct roles.

Each of them is vitally important:



Infographic: Mike Masding / Katie Knight

NB in some placements, especially in year-long specialty training posts, the Educational Supervisor and Named Clinical Supervisor roles may be carried out by the same person.



Roles and Responsibilities:

Learner responsibilities

Doctors in training are asked to take responsibility for their own development as adult learners. Educational and Clinical Supervisors will support the trainee but will not take over the trainee's responsibilities to engage with the available elements of specialty training. The trainee must familiarise themselves with relevant specialty curricula, assessment requirements and documentation at the beginning of their programme and at each new placement or rotation.

For further information, please refer to the [Gold Guide](#).



Educational Supervision

An **Educational Supervisor (ES)** is a named individual who is responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time (often a year). They remain ES as a trainee moves through different clinical placements. They may be in a different department to the trainee, but **must be available – this involves being both accessible and approachable**. If the trainee is placed in their department, the ES may also act as the named Clinical Supervisor for that placement and must understand these responsibilities.



The quality of the relationship between supervisor and trainee is probably the single most important factor for effective supervision.^[6]



The role of the Educational Supervisor is to encourage their trainee to be the best that they can be. 'Education' has no defined curriculum, no start, no end - and is a process by which professionals learn from their seniors through observation and discussion.

The role is not about ensuring the boxes are ticked in the eportfolio. It is about supervising, talking, supporting and discussing - in a safe and supportive environment - anything and everything related to being a doctor within the current and future NHS.

The Educational Supervisor – Trainee relationship is about mutual respect, trust and maintaining an adult to adult conversation.' Dr Liz Spencer^[7]

A named educational supervisor must complete and maintain a record of professional development relevant to the role, with evidence within the seven domains outlined in the professional development framework^[8]

NHS Employers holds information for Educational Supervisors that is specifically related to the 2016 contract^[9]

Roles & Responsibilities of an Educational Supervisor - NACT UK

Educational Supervisor Responsibilities, Gold Guide, A Reference Guide for Postgraduate Specialty Training in the UK (7th Edition published January 2018)

Clinical Supervision

NAMED Clinical Supervisor (NCS)

This is a **named consultant** working within the same department during a trainee's placement who **oversees the trainee's clinical development on that placement**. The NCS is responsible for producing the end of placement report for ARCP. They may not often work directly alongside the trainee, so should gather information about the trainee's performance from other members of the multidisciplinary team (workplace supervisors) which can be used in the end of placement sign-off.

The feedback to an NCS can be more formalised (typically for Foundation Year doctors or ACP trainees) by creating a Placement Supervision Group (see below).



With appropriate consultant support, a senior registrar can be appointed as a Named Clinical Supervisor for a more junior trainee (typically at junior SHO level). This arrangement can allow a closer working relationship between a junior trainee and their NCS, while also providing a senior trainee with valuable experience in supervision.

Clinical Supervisor (on each shift)

Every trainee must, at all times on a shift, be responsible to a nominated consultant. This will usually be the on-call consultant for the specialty the trainee is working within, who holds overall responsibility for the patients. Every trainee should always know the name of this individual on each shift and how to contact them.

The consultant must be available to advise and assist the trainee as appropriate. Sometimes this will require the consultant's urgent presence but, on many occasions, less direct involvement will be needed.

[Clinical Supervisor Responsibilities](#), Gold Guide, A Reference Guide for Postgraduate Specialty Training in the UK (7th Edition published January 2018)

Workplace Supervision

Every trainee doctor needs some degree of supervision in the workplace. The less experienced the trainee, the more direct supervision they will require.

A workplace supervisor can be **anyone within the multiprofessional team who is competent to carry out the task in question**.

Examples include but are not limited to

- A prescribing pharmacist can supervise a trainee doctor writing a drug chart
- An Emergency Nurse Practitioner can supervise a trainee doctor suturing a patient's wound

- A registrar can supervise a more junior trainee doctor assessing and managing an acutely unwell patient
- A senior nurse can supervise a trainee doctor managing a patient's catheter
- A Foundation Year 2 doctor can supervise a Foundation Year 1 doctor cannulating a patient

Workplace supervisors have delegated authority from the Clinical Supervisor with overall patient responsibility (usually the on-call consultant for the shift). Any concerns about a trainee's clinical performance should be communicated between the workplace supervisor and clinical supervisor.

Handover meetings, briefings & de-briefings, and Hospital-at-Night teams form part of workplace supervision. As part of their workplace supervision, healthcare professionals should routinely inform the trainee's Named Clinical Supervisor and Educational Supervisor about the performance of the doctor in the workplace.

Supervision of one trainee doctor by another

Senior trainees must gain the knowledge, skills and professional judgement to supervise safely and effectively; **providing workplace supervision is therefore an essential part of training**. A senior trainee's ability to provide appropriate workplace supervision to other members of the multiprofessional team should be evaluated through workplace-based assessments.



Placement Supervision Group

This form of supervision is encouraged for Foundation Trainees as best practice in providing supportive feedback.

The Foundation trainee's Named Clinical Supervisor should formally identify a Placement Supervision Group (PSG) for every trainee. This group should consist of a minimum of 3 individuals, representing different members of the multi-disciplinary team, including senior nursing staff, senior doctors, and allied healthcare professionals. The purpose of the PSG is to provide feedback on clinical performance; feedback on attitudes and behaviours is collected separately in the trainee's TAB assessment each year.

Those who are part of the trainee's PSG should be in position to work with the trainee on a regular basis so that they can provide informed, constructive feedback specific to the learning needs of the trainee. Those identified as part of the PSG should be asked if they are happy to undertake this role at the start of the trainee's placement, and should also be consulted at the end of the placement to provide feedback, to be used in the trainee's end of placement sign-off.

The Multi-professional Learning Environment

HEE worked with the RCP to provide the guidance document '**Never too busy to learn: How the modern team can learn together in the busy workplace**'^[10]. Recognising the pressure on individual trainees and supervisors and the changing patterns of work, this guidance highlights for both supervisors and doctors in training how to make the most of every learning opportunity and the support of the multi-professional team.

Other Models of Supervision

Supervision is typically a one to one activity, and the importance of this relationship should not be underestimated.

However, other models of supervision may **supplement and complement** the 'traditional' one to one supervision model. Small group supervision centers on peer group discussion between 6-8 individuals, facilitated by a group leader who is typically more senior.

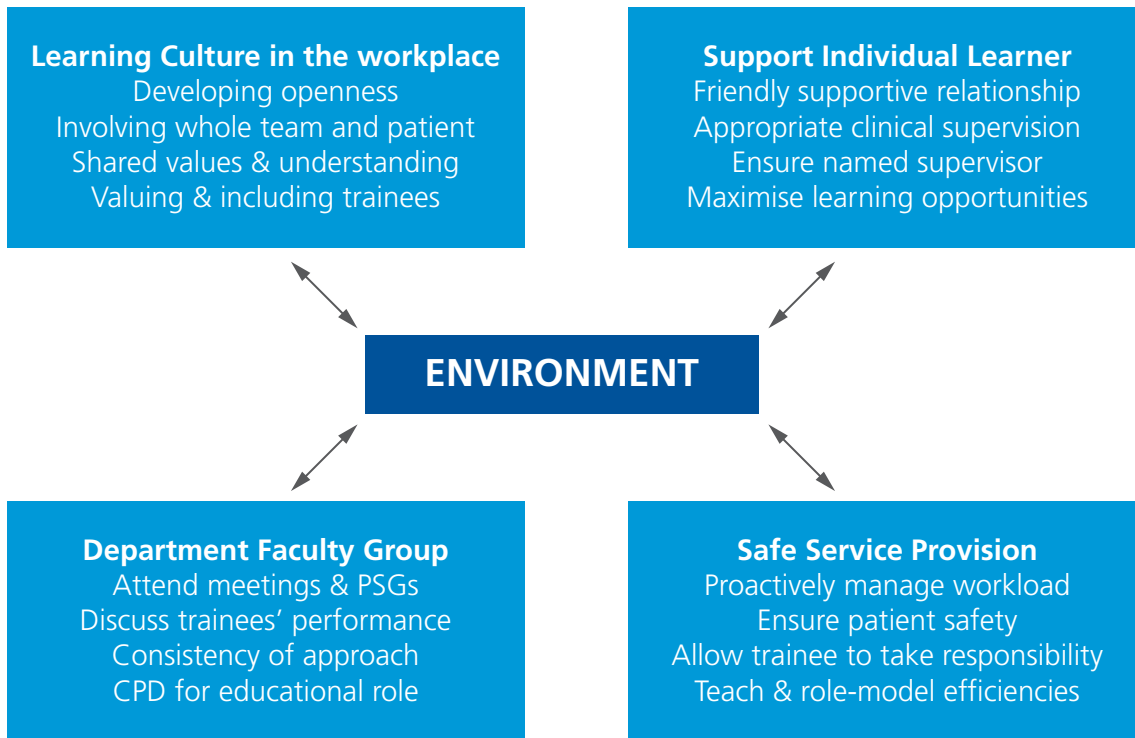
Balint groups are a form of group supervision in which where interpersonal aspects of work with patients can be discussed in a psychologically safe space.^[11]

Action Learning Sets are a similar model which arose in the management environment but have been used extensively in a healthcare setting. Action learning is based upon the concept of learning by reflection (or reviewing) on an experience. It is underpinned by the cycle of experiential learning.

The Foundation Programme Review recommends that the use of these and other alternative models of supervision is trialled with Foundation Programme trainees.

HEE also encourages the trial of these alternative supervision methods as a supplement to traditional supervision with groups of trainees outside the Foundation Programme.

Best Practice - the Local / Department Faculty Group



From NACT Faculty Guide ^[12]

The General Medical Council defines '**local faculty**' as "those involved in the delivery of postgraduate medical education locally". This includes local foundation programme directors, directors of medical education, clinical tutors, GP trainers, college tutors, and others with specific roles in educational supervision and clinical supervision.

In general, trainees work within a specialty department for a group of consultants who supervise their postgraduate medical training. One consultant usually leads, organises and coordinates these educational activities – and is responsible for liaison with the hospital medical education infrastructure.

The "Extended" Faculty

Every member of the clinical team in which a trainee is working has a role to support that learner. Trainees are also members of this "extended faculty" as they are key in supporting the learning of those more junior than themselves. It is the responsibility of the local faculty to ensure that all members of the extended faculty understand this educational role and feel supported by the named members of the local faculty.

Department Faculty Group

All departments with trainees should hold a regular Department Faculty Group meeting. Faculty members with specific roles will attend this meeting and feedback key information to all members of their clinical team, including those from other departments, specialities and professions where appropriate. **Department faculty groups should have trainee representation at each meeting; however the trainee representative should not be present for discussions about individual trainee performance or trainees in difficulty.**



The role of the Educational Supervisor is to encourage their trainee to be the best that they can be.

Department Faculty Groups should report directly to the **Director of Medical Education**.

Department Faculty Group meetings address issues such as

- Service provision / training needs conflicts
- Mismatches between trainee / ES
- Conflict resolution, mediation
- Trainees in difficulty
- Trainees at end of training / CCT
- Training needs of trainers / CPD requirements
- Rota issues, service reconfiguration
- Discuss performance of all trainees
- Developing processes and guidelines to ensure consistency of both educational & clinical approach between individual faculty members

NACT Faculty Guide

Good Practice, Poor Practice

Good Supervision

The appendix to this document 'Case Studies in Good Supervision', and the Royal College of Physicians document, 'Never too busy to learn' (2018)^[10] give further detail regarding how various departments have developed innovative ways to support educational and clinical supervision.

Good supervision has its foundation in processes which should be common daily practice; it creates an environment which prioritises patient safety and encourages ongoing learning that all team members can participate in and benefit from.

The desired attitudes and behaviours of an effective supervisor include but are not limited to:

- Approachable manner
- Facilitates learning
- Knowledgeable about own area of practice; aware of own limitations
- Models good practice in own interactions with patients and other professionals
- Adapts supervision style according to needs of trainee
- Inclusive and aware of own unconscious biases
- Actively seeks professional development to keep supervision skills up to date
- Able to provide pastoral care where needed
- Will be appropriately supportive to a trainee who is having difficulties in their personal or professional life

In broad terms, good supervision:

- Involves all members of the multiprofessional team, recognises the contribution of all team members
- Sets out clear lines of escalation – all team members should know how to escalate a clinical concern and feel supported to do so

In acute settings, good supervision:

- Emphasises the importance of handover (which should take place at the start and end of each shift) and use these events as an educational opportunity
- Makes use of regular briefings or 'huddles' in between handovers to ensure patient safety and that the team remains connected

Ineffective Supervision

Health Education England believes that it is important to illustrate specific examples of poor practice in supervision so that they can be discouraged and eliminated.

These are all examples that we have heard directly from trainees in the process of this review.

- Difficulty in contacting individual with overall clinical responsibility (Clinical Supervisor)

Trainees have reported instances of being unaware of who their Clinical Supervisor is for a shift, or being unable to contact them. When there is no specified or contactable Clinical Supervisor and a trainee has to spend time (possibly leaving the department) trying to find one, this is a patient safety issue.

The lines of escalation in the event of a clinical concern must be clear to all members of the multiprofessional team. If the Clinical Supervisor will not be immediately contactable (for example if they are scrubbed in theatre) they must nominate a deputy who is able to respond to trainees requiring senior support.

- Poor teamwork

Poor teamwork lays the foundation for ineffective supervision and negative experiences. Specific examples of poor practice include

- Sending the most junior member of the team (usually the Foundation trainee) off routinely 'to do jobs' during the ward round; although this may seem as if it would improve efficiency, the trainee then misses out on learning about the patients the team are responsible for (and may miss hearing vital clinical information).
- Not explaining to junior team members why certain investigations or scans are required, and yet expecting them to be able to explain and justify them to senior colleagues in other departments (e.g. radiologists)

- Expecting trainees to be able to perform procedures outside of their competence or belittling their lack of experience when they state that they are not confident in a particular procedure.
- Lack of feedback on performance (informal immediate feedback from multidisciplinary team)
- Making negative comments about colleagues from other specialties or multidisciplinary team members; undermining decisions made by other professionals
- Inappropriate behaviour by seniors towards junior colleagues

Workplace incivility has direct negative impacts on patient safety. Lack of common courtesy in interactions between junior and senior colleagues leads to poor relationships and ineffective supervision.

Examples are things such as supervisors not taking the time to remember their junior trainees' names; being rude to juniors, or about other juniors or colleagues; and making disparaging comments about trainees now versus 'in my day'.

Support to Improve Supervision

There are multiple reasons for driving up quality in trainee supervision. There is an evidenced relationship between **professional well-being, recruitment and retention and compassionate care** ^[13], therefore effective supervision relates directly to patient safety. At an organisational level, the drive to improve patient care must be inclusive of improving working conditions for all staff.

The NHS Log Term Plan and subsequent NHS People Plan set out a system wide commitment to making the NHS the best place to work, improve workplace well-being and specifically committed to delivering improvements in supervision in order to improve training. Collectively, we also committed to developing and delivering this supervision toolkit.



A national Joint Strategic Oversight Group (JSOG), chaired by the CQC and involving NHS England and Improvement, HEE and GMC meet bi-monthly to share information, concerns and support information on Trusts within the regulatory 'Special Measures' regimes and includes information from HEE and GMC around quality concerns within education and training.

As supervision has significant correlation with patient safety and service efficiency, intelligence about the quality of supervision is a key strand in discussion and joint approaches to supporting improvement.

Health Education England (HEE)

HEE is responsible for ensuring that there are high quality learning environments for all healthcare learners.^[14] This responsibility includes the funding, quality management and organisation of post graduate medical education and ensuring that local organisations providing education adhere to the regulatory standards set by the GMC and other Professional Regulators.

HEE sets out the standards and expectations of providers for supervision and through our Learning and Development Agreement (LDA) with providers, the funding associated for it, as placement tariff, is identified.

HEE's Quality Framework sets out what is expected of a well-led and high-quality clinical learning environment through a broad multi-professional approach to quality management.



Whilst all of the six domains of the QF are important, the standards set out supporting and empowering educators and learners are central to the supervision aspects of training. During 2019/20, HEE will place a focus on reviewing and supporting improvements in supervision through our quality management processes underpinned by the Quality Framework.

[HEE Quality Framework](#)

[HEE Intensive Support Framework](#)

[HEE Learning And Development Agreement](#)

General Medical Council (GMC)

Where there are concerns about training, HEE work with trusts to identify sustainable solutions and agree plans to make improvements.

However, if the situation doesn't improve and there are concerns about the quality and safety of training, HEE works in partnership with GMC using their levers as a professional regulator, using the GMC Enhanced Monitoring process.

GMC expectation is for trainers to have sufficient, explicit time in job plans for both educational and clinical supervision of trainees. ^[15]

Doctors who have been registered with the GMC by their LEP and local education and training board (LETB) as a named postgraduate clinical OR educational supervisor have a note on their medical register entry to say 'this doctor is a trainer recognised by the GMC'. ^[16]

The GMC recognition and approval process is aligned to the Academy of Medical Educators' (AoME) Professional standards for medical, dental and veterinary educators (2014). The AoME standards were updated in 2017 and are used for current approval and recognition within London. ^[8]

[GMC Enhanced Monitoring](#)

Statements from Health Education England



Health Education England exists to support the delivery of excellent healthcare and health improvement to the patients and public of England. One of the many ways we work towards this goal is to ensure that doctors in training are provided with world class education and training, and are supported to achieve their full potential.

We value the vital role played by all the supervisors of doctors in training. We also recognise that the traditional model of a senior doctor having sole oversight of a junior doctor's training is outdated and does not reflect the fact that in the modern clinical environment, aspects of supervision are provided by many different members of the multidisciplinary team. This greatly enriches not only the trainee doctor's clinical experience, but also enhances the multi-professional working of the whole team.

The 'Enhancing Supervision' report and toolkit highlights this and formally recognises the crucial Workplace Supervisor role for the first time.

The collaborative work with NHS England / Improvement and the CQC who supported Health Education England with this piece of work, signifies the strong commitment that exists across the NHS to improving patient safety by ensuring that doctors in training are always given the support that they need.



Professor Wendy Reid

Executive Director Education and Quality and
Medical Director



The publication of 'Enhancing Supervision' is an important step forwards in Health Education England's ongoing work to improve junior doctors' working lives. Although the provision of safe supportive supervision is essential for both doctors and patients, there are times when this is not optimal. We hope that by clarifying what supervision is, and how it should be experienced, we will help trainees, supervisors and employers to ensure high quality supervision is available for all doctors in training.

We would like to thank the many individuals in the CQC, NHSI, NHS Employers and NACT who have worked closely with Health Education England on this set of resources, and our wider stakeholders including the BMA Junior Doctor Committee, the GMC and the educator faculty in Trusts who contributed with examples of best practice.

We would especially like to thank Dr Katie Knight for her work on this, with the support of Dr Rose Penfold and Dr Helen Grote, clinical fellows from NHSI and the CQC, in the development of this helpful resource.



Sheona McLeod

Professor Sheona McLeod

Deputy Medical Director for Education Reform

Care Quality Commission (CQC) Statement on Effective Supervision



'The Care Quality Commission (CQC) recognises that high quality leadership, promoting a positive workplace culture, in which staff are well supported, ultimately improves the quality of care for patients. CQC inspectors assess service against key lines of enquiry (KLOEs) in the regulatory framework: Safe, Effective, Caring, Responsive and Well led'

As part of assessing how Effective a service is, inspectors need to ensure that staff have the 'skills, knowledge and experience to deliver effective care, support and treatment' (KLOE E.3). This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.

In the Well led domain, the workplace culture is assessed; this includes whether staff feel supported respected and valued (KLOE W 3.1), whether staff feel able to raise concerns without fear of retribution (W3.5) and whether there is a strong emphasis on the safety and wellbeing of staff (W.7).

These key lines of enquiry are assessed against professional standards eg. 'Eight High Impact Actions to Improve the Working Environment of Junior Doctors'.

To establish the performance of the provider in providing effective supervision for staff (including junior doctors), the CQC interviews the Guardian of Safe Working Hours on annual well-led inspections, and has committed to holding regular junior doctor focus groups as part of their monitoring phase. In addition, data from the GMC trainee survey is also incorporated as part of the dataset supplied to regional inspection managers in advance of a well-led inspection.

CQC inspectors will use information from these focus groups and interviews to establish whether junior doctors are adequately supervised and supported, and this will feed into the overall rating for the trust as 'outstanding'; 'good'; 'requires improvement' or 'inadequate'. Where appropriate, inspection reports may also carry recommendations as to what the provider should or must do to improve supervision and the workplace culture.

Junior Doctors who have concerns about their trust at the provider level can also provide information in person, or anonymously to the CQC via the national customer service centre on 03000 616161'



Prof. Ted Baker
Head of Hospital Inspections
Care Quality Commission
January 2019

NHS England and NHS Improvement



NHS England and NHS Improvement are committed to ensuring high-quality and safe patient care. We recognise that to achieve this aim, doctors-in-training need to be effectively supported and supervised in their clinical learning environments. This is aligned with overarching aims of the recently published Interim NHS People Plan: valuing, supporting, developing and investing in our current and future workforce. The Interim NHS People Plan outlines a specific commitment to ensure that doctors-in-training have appropriate and consistent supervision and to deliver measurable improvements in the capacity and quality of supervision across the NHS.

We are already actively engaged in work to improve the experiences of doctors-in-training. Working with a range of trusts, NHS Improvement, FMLM and NHS Providers identified Eight High Impact Actions to Improve the Working Environment for Junior Doctors and potential solutions suggested by doctors. NHS Improvement is working in partnership with HEE, providing national level direction to support local providers to improve induction processes for doctors-in-training rotating between employing organisations. There is ongoing work to address issues surrounding effective implementation of the 2016 Junior Doctor Contract terms and conditions of service, including an NHS Improvement-led cross-party working group to improve exception reporting processes for doctors-in-training and guardians of safe working.

NHS England and NHS Improvement will work directly with provider organisations to raise awareness of this guidance for supervision and support providers to effectively implement recommendations and standards for supervision in clinical learning environments.



Celia Ingham-Clark
Medical Director for Clinical Effectiveness





The quality of the relationship between supervisor and trainee is probably the single most important factor for effective supervision. ^[6]

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