

IMT YEARS 1&2 PLACEMENT QUALITY REVIEW 2021

Northern Ireland Medical and Dental Training Agency
REPORT COMPILED BY DR S.A.PHILLIPS & MR W ELBARONI

Review members

Dr Sally Anne Phillips (Associate Dean for Placement Quality)

Mr Wesam Elbaroni (ST5 Urological Surgery, ADEPT Clinical Leadership Fellow 2021/22)

Dr Ian Steele (Postgraduate Dean, NIMDTA)

Dr Janet Harding (Head of School, Internal Medicine)

Dr Marguerite McCloskey (Training Programme Director- IMT Years 1-2; Deputy Head of School)

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Executive Summary

The core medical training programme (CMT) was replaced in August 2019 by the new Internal Medicine (IMT) Stage 1 Training programme ⁽¹⁾. The purpose IM stage 1 training, is *'to produce doctors with the generic professional and specialty specific capabilities needed to manage patients with a wide range of general medical symptoms and conditions'*. It is normally a three year programme that includes mandatory training in geriatric medicine, intensive care, outpatients and ambulatory care. This summary document details the information received from a Placement Quality Survey sent to all IMT Year 1 and Year 2 trainees in July 2021; providing feedback from trainees on the first two years of the new IMT training programme.

The Placement Quality (PQ) Review of Specialty Training Programmes started in August 2018. The aim of this work is *"To optimise patient-centred care through quality improvement of medical training posts within Northern Ireland, involving rigorous review of current placements, active engagement with trainees, trainers and providers, and the development and implementation of strategies to improve current practice within medical training."* The PQ review adds to the existing information available from NIMDTA deanery visits and the GMC National Training Surveys (NTS), providing a more detailed specialty specific assessment of the quality of training posts in Northern Ireland.

A PQ Review of Internal Medicine Training (IMT) in Years 1 and 2 was completed in July 2021. The first step in the process was to review the new IM stage 1 curriculum and educational framework to confirm the IM stage 1 training requirements. ⁽¹⁾ Feedback from the Head of School of Internal Medicine and the Training Programme director for IM stage 1 training was then used by the Placement Quality team to compile a detailed survey to assess the quality of training placements. The survey was circulated to all trainees working in IMT 1 and IMT 2 placements between February and July 2021. The survey was open for three weeks in July 2021. The response rate was 57% (54/95). The balance of respondents was 44% (24/54) IMT1 trainees and 56% (30/54) IMT2 trainees.

Section 1 of this report summarises the results of the survey under the following headings:

1. Rota Allocations and Induction
2. Educational Supervision, Clinical Supervision and Feedback
3. Clinical Workload
4. Regional and Local Departmental Teaching
5. Training Opportunities (CiPs; Practical procedures and Quality Improvement)
6. Overall Opinions and Trainee Suggestions for Improvement

Section 2 highlights the identified good/transferrable practice and sets out the agreed local actions for improvement.

To ensure improvements are maintained and to assess the success of additional measures that have been introduced to further improve the training experience, the Placement Quality Team at NIMDTA will be conducting a further survey of all trainees in IMT training placements in late 2022/ early 2023.

Section 1: Analysis and Recommendations

1. Rota Allocations and Induction

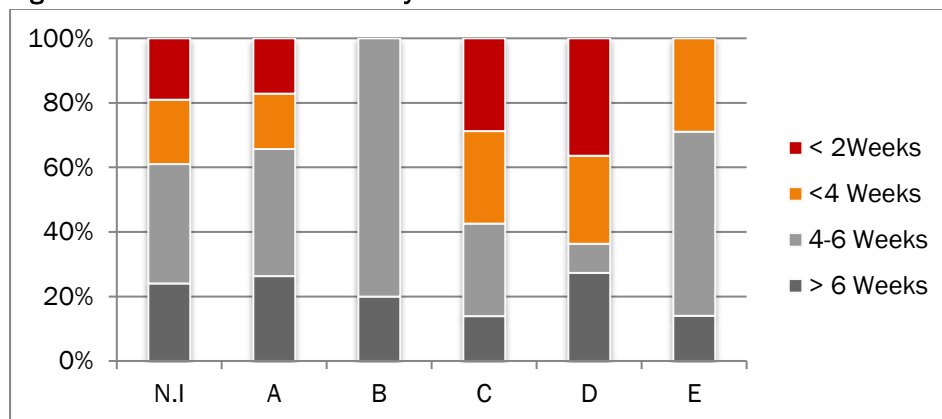
Rota Allocations

It is a requirement of the Learning and Development Agreement between NIMDTA and Local Education Providers (LEPs) that information relating to the allocation of trainees within training programmes is provided to LEPs 8 weeks in advance of the changeover date.⁽²⁾ Trainees are notified by NIMDTA of their post allocation at this time and Trusts are then required to inform trainees of their out of hours (OOH) rota allocation at least 6 weeks before the commencement of their post.⁽³⁾

Regionally over a third (39%) of trainees received less than 4 weeks' notice of their on-call rota from their Trust, with 1 in 5 (19%) having less than 2 weeks' notice and 45% indicating that notification of the rota was not adequate time for personal/professional preparation.

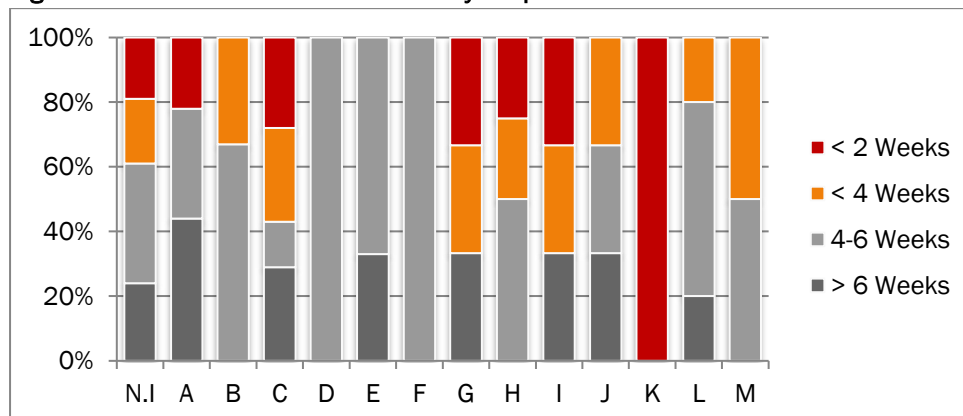
In only one Trust (Trust B) did ALL trainees receive at least 4 weeks' notice of their on-call rota, with 20% of trainees in this Trust having 6 weeks' notice (Figure 1).

Figure 1: Notification of OOH rota by Trust



There was variation in rota notification across hospital sites with earlier rota notification noted in sites A and L, where at least 4 weeks' notice of OOH arrangements was reported by around 80% of trainees and in sites D, E and F, where ALL trainees received at least 4 weeks' notice. In contrast in hospitals C, G and I, less than 4 weeks' notice of OOH rota arrangements was reported by around two thirds of trainees (Figure 2). No trainees reported that they had received notification of their OOH commitment on the day of starting their post.

Figure 2: Trust notification of OOH rota by hospital site



It was recognised by NIMDTA and the School, that National and local recruitment processes can delay final confirmation of trainee numbers to the Trusts contributing to delays in rota notification.

Trainee free text comments

'Rota provided 1 week before starting. As 6 weeks' notice is required for leave approval this means you could not take leave in 1st month of placement. This means that currently at the end of placement they are under staffed' (Trust D)

'General medicine on-call rota was sent out with little time to start date despite being a rolling rota' (Trust D)

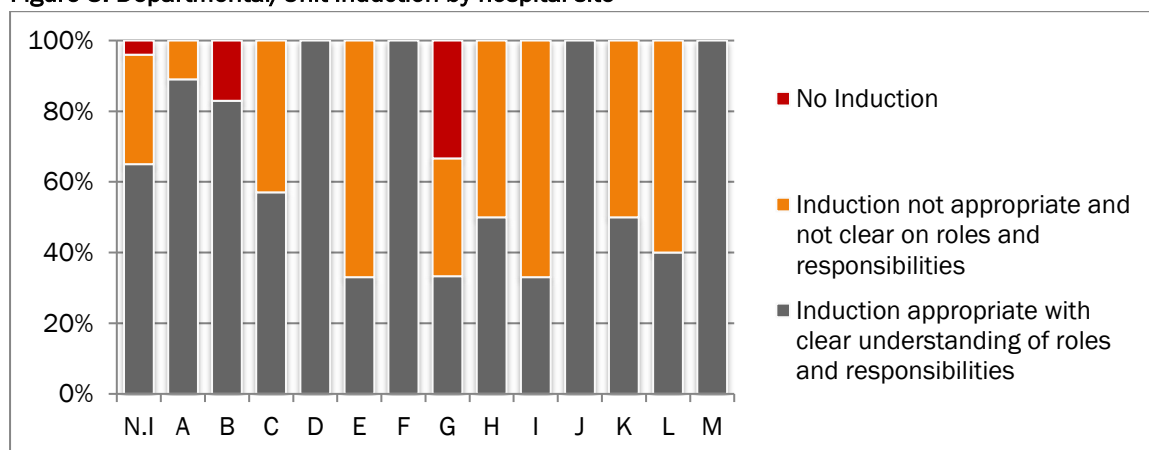
Induction

The GMC's Promoting Excellence sets out the requirements for Trusts to provide an induction at the start of a placement with clearly defined aims. ⁽³⁾

Regionally the majority of trainees (65%) reported that their induction to their placement was appropriate, providing a clear understanding of their roles. In Trust A this figure reached 78%, above the regional figure although still short of the target of 100% (Appendix 3).

There was variation in trainee feedback on induction between sites (Figure 3). In hospitals D, F, J and M all trainees reported induction as appropriate. While in hospitals E, G, H, I, K and L induction was reported as unsatisfactory by between half and two thirds of trainees. One trainee in sites B and G reported not receiving an induction to their department.

Figure 3: Departmental/Unit Induction by hospital site



Trainee free text comments

'Induction should be held by medical staff who know the hospital, not the rota coordinator' (Trust D)

'Importance of on-site ward/local induction by clinical supervisor or lead Consultant on start date (Trust D)

Feedback from Trust visits in 2021 indicated that over the past 18 months, due to COVID imposed restrictions, induction has been delivered using a combination of online and face to face modalities. In areas where there was positive feedback on the induction process there was a significant face to face component to induction; whereas in sites where face to face involvement in the departmental induction process was significantly reduced or absent feedback was in general more negative. The importance of a face to face introduction to the department, by a trainer/doctor working in that area was repeatedly highlighted by trainee comments.

Key Recommendations: Rota Allocation and Induction

Trusts should provide all trainees with information of their OOH rota at least 6 weeks prior to post commencement

All trainees, in addition to online information, should have a face to face induction to their department/unit and receive clear guidance on their specific roles and responsibilities

2. Educational Supervision, Clinical Supervision and Feedback

Educational Supervision

Regionally educational supervision was rated very highly, with 91% of respondents rating the quality of supervision from their Education Supervisor (ES) as satisfactory and 68% reporting it as excellent/above average (Figure 4). In Trusts A, C and E the number of trainees reporting their Educational Supervision as excellent/above average was 86%, 83% and 86% respectively, above the regional figures.

In 4 hospital sites (B, F, H and M) educational supervision was reported as excellent/above average by ALL trainees. Poor educational supervision was reported by just 9% of respondents (4 trainees) and all reports related to 3 hospital sites – sites I, K and L (Figure 5).

Figure 4: Quality of Education Supervision by Trust

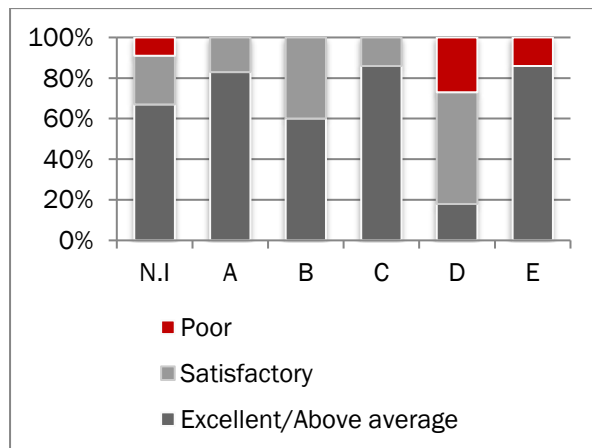
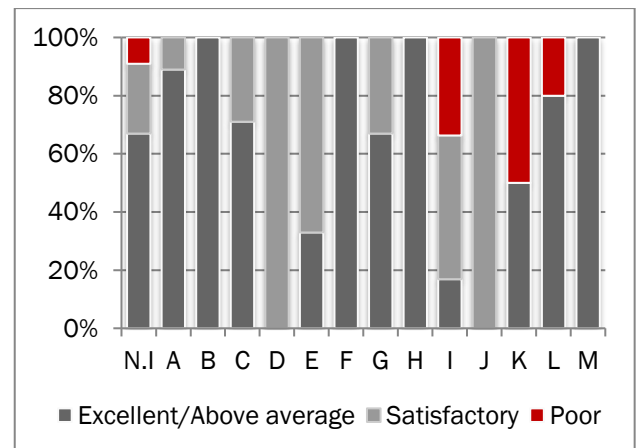


Figure 5: Quality of Education Supervision by hospital site



Trainee Free Text Comments

'I have received absolutely exemplary support from my educational supervisor' (Site A)

'Extremely helpful very approachable really endeavoured to be supportive at all times' (Site C)

'She would spend time to make sure the trainee is on the right track, giving useful advice and provide assistance when needed. She is also willing to spend her time with trainee to discuss about challenging situations' (Site B)

'Supportive and approachable ES. Always available to provide advice and motivation to further my clinical progression' (Site C)

'Always approachable, encouraging and would help in any way. Felt supported' (Site L)

'Very engaging. Good support. Well aware of progress' (Site H)

'Very approachable and understanding of training needs. Would meet via zoom regularly and appointments would be sent in advance' (Site I)

Clinical Supervision

When asked to rate the quality of senior clinical supervision during normal working hours the number of trainees reporting clinical supervision as acceptable was 94%, with 51% rating this as excellent/good. This level of supervision was maintained OOHs with 94% rating clinical supervision as acceptable and 34% as excellent/good (Figures 6 and 7).

In the majority of hospital sites the quality of senior clinical supervision remained high regardless of day time or out of hours working. ALL trainees reported clinical supervision as acceptable both during normal working hours and out of hours in 10/13 hospital sites.

The quality of senior supervision during normal working hours was reported as less than satisfactory by one respondent in hospitals A, E and I and out of hours by one respondent in hospitals A, F and H.

Figure 6: Clinical Supervision during normal working hours by hospital site



Figure 7: Clinical Supervision OOH by hospital site



Regionally the majority of trainees report feeling well supported by senior trainees (80%) and consultants (74%) when work intensity is excessive. It is noted that there is no senior trainee in site F.

Trainee Free Text comments

Supervision mostly provided by registrar team and although it was generally of a high standard would expect more consultant engagement' (Site B)

'There isn't much clinical work that requires supervision' (Site K)

'Most senior person on site' (Site F)

Feedback

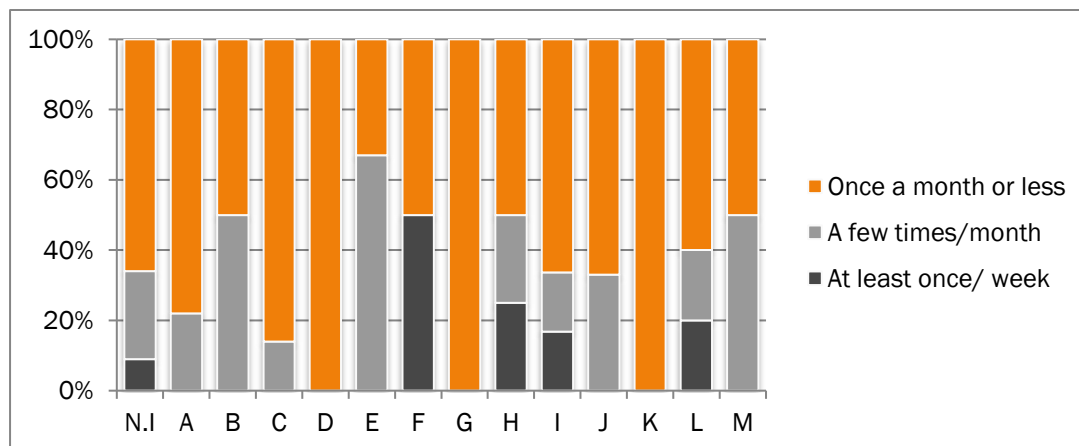
The GMCs Promoting Excellence: standards for medical education and training ⁽³⁾ in its requirements related to supporting learners states in section R3.13 that

"Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it."

Regionally the majority (67%) of IMT1&2 trainees indicated that they had received feedback on their performance once a month or less, with 1 in 5 trainees (19%) reporting that feedback was not provided. Feedback at least a few times a month was reported by only a third of respondents (Figure 8). Just 9% of trainees reported receiving regular weekly feedback

There was however variation in results between sites, with hospitals B and E delivering feedback a few times a month to 50% and 67% of trainees respectively; while in hospital C, D, G and K results were significantly below the regional figures with 86% of trainees in C and ALL trainees in sites D, G and K indicating they had received feedback only once a month or less.

Figure 8: Frequency of trainee feedback by hospital site



When received, the quality of feedback was reported regionally across all Trusts as constructive and supportive, improving clinical practice and developing leadership skills.

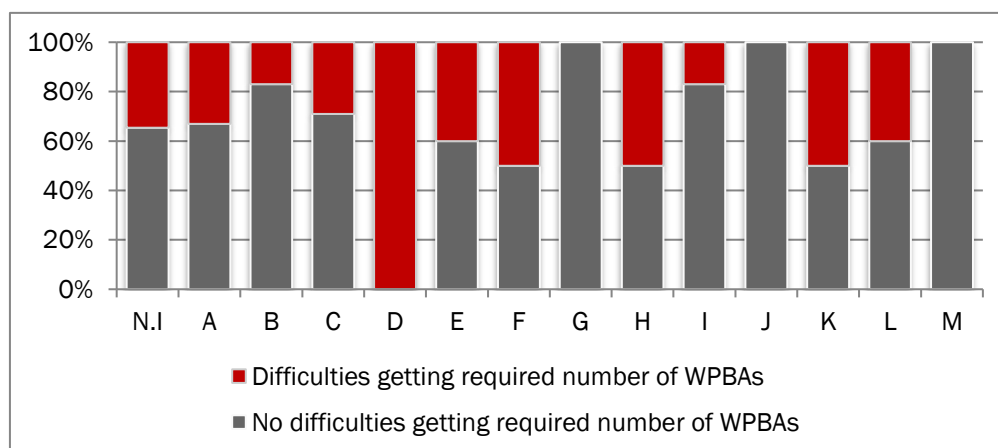
Trainee Free Text Comments

'Feedback provided in portfolio assessments only' (Site I)

Workplace Assessments (WPBAs)

Regionally 72 % of trainees reported no difficulties getting the recommended number of WPBAs needed for progression. In hospital sites D, F, H and K at least half of trainees reported issues getting the number of WPBAs required (Figure 9). It is noted that on some sites the absence of an acute medical take and the nature of the patient profile limits WPBAs during some placements.

Figure 9: Issues getting WPBA by hospital site



Trainee Free Text Comments

'Many opportunities for procedures but due to limited staffing attempting many are not attempted' (Site F)

'It is very hard to complete these with the way work is structured. We see the most new patients on the medical take and this would be ideal for discussing in a WPBA/SLE, but usually the person clerking the patient in is not the same person who gets to attend the post take ward round. Therefore it's difficult to find an opportunity to get WPBA' (Site E)

'Difficult to complete assessments as not in acute hospital therefore no procedures. Consultants only on the ward couple of times per week. Usually not able to go to clinic due to staff shortages on ward' (Site C)

'DOPs have been difficult. Opportunity for them has not come up therefore very little experience gained in some procedures' (Site D)

Key Recommendations: Educational Supervision, Clinical Supervision and Feedback

An ongoing commitment to deliver high quality educational and clinical supervision to IMT trainees is evidenced by trainee feedback across all training units in the School of Medicine. This is to be commended.

The lack of regularly delivered feedback to trainees is highlighted as a regional issue.

Clinical supervisors /consultant trainers should provide informal feedback to all IMT trainees at least a few times a month

3. Clinical Workload

Regionally two thirds of all IMT1&2 trainees reported that clinical workload was just right during the day and at night, however there was significant variation across hospital sites (Figures 10 and 11).

In 6 hospital sites (D, H, J, K, L and M) an appropriate workload during the day was reported by ALL trainees, but in 4 hospitals (E, F, G and I) daytime workload was reported as very intense/excessive by 67%, 100%, 67% and 67% of trainees respectively, above the regional figure of 31%.

In hospital sites B, C, D, J, K and M, all trainees reported a well-balanced workload at night, above the regional figure of 66%. In hospitals F, G, I and L however the majority or all of trainees reported the workload at night as very intense/excessive, compared to the regional figure of 34%; with two thirds of trainees in site G indicating that the workload at night was excessive (regional figure 15%).

Figure 10: Daytime workload by hospital site

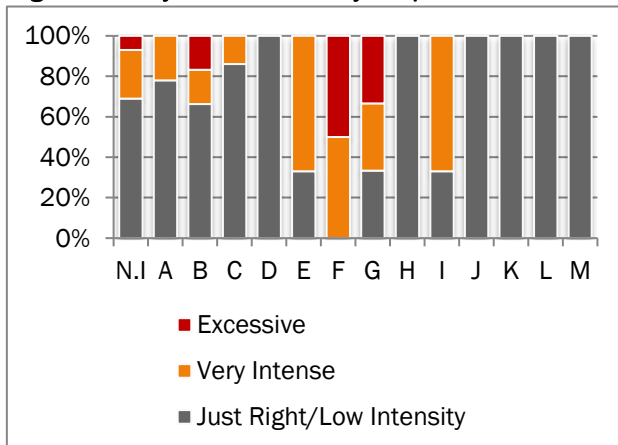
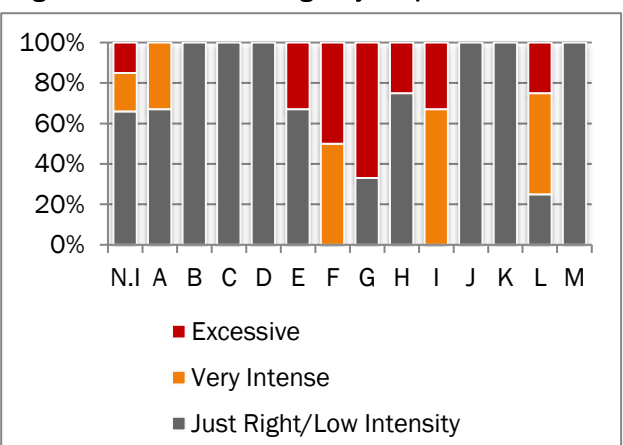


Figure 11: Workload at Night by hospital site



During Long Days and at weekends workload intensity was higher and was reported as very intense/excessive regionally by 45% and 61% of trainees respectively. Excessive work load was reported by 13% during a long day and by 20% at weekends.

In hospitals F, G, H, I and M the figures for workload intensity during a long day were above the regional average with the majority or all trainees indicating that the workload was very intense/excessive (Figure 12). In hospitals F and G it is noted that workload during a long day was reported as excessive by 50% and 33% of respondents respectively (regional figure 13%).

A well balanced workload at the weekend was reported by over two thirds of trainees in only 3 hospital sites (D, E and K). In 7 hospital sites, the majority of trainees reported that workload at the weekend was very intense/excessive. In 4 of these sites (F, G, I and M), all trainees reported workload at the weekend as very intense/excessive with 100% and 67% of respondents in sites F and G respectively reporting workload as excessive (regional figure 20%).

Figure 12: Long Day workload by hospital site

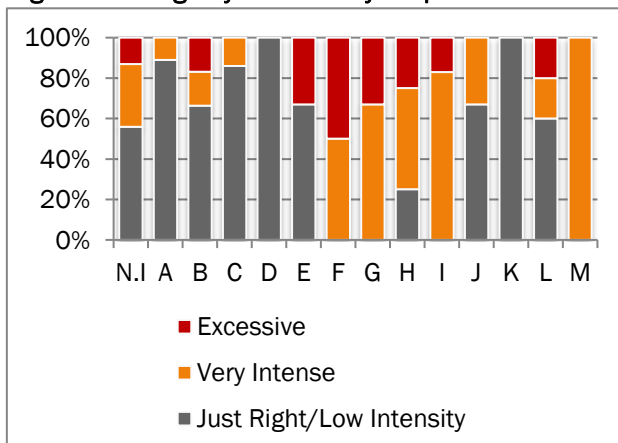
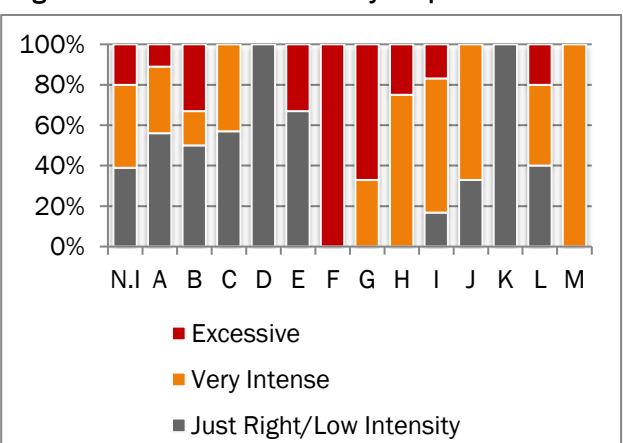


Figure 13: Weekend workload by hospital site



Trainee Free Text Comments:

'Medical Take in A&E is always busy, the ward SHO is required to help the take. This badly affects the care of patients at ward level where sometimes a JHO has to deal with a really sick patient. Med SpRs are limited in number; one Registrar is not enough to cover wards, referrals and HDU and also to see sick patients in A&E' (Site H)

'Extremely busy. Very inadequate staffing levels at most times, burned out' (Site F)

'After nights, Post- take ward rounds would finish very late in general medicine and cardiology. Cardiology cover during the day included being on post take, covering day admissions and daily ward round of patients which was very intense. Challenging to get breaks. (Site I))

4. Regional and Local Departmental Teaching

The GMCs Promoting Excellence: standards for medical education and training ⁽³⁾ in its requirements related to supporting learners states in section R1.16 that

"Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety."

Regional Teaching

Good attendance at regional teaching sessions was widely reported. Regionally 87% of trainees were able to attend at least 50% of sessions with attendance at >75% of sessions reported by 28% of trainees (Figure 13). In addition around two thirds of respondents (63%) reported having to attend less than half of these sessions in their free time i.e. attendance was scheduled into their work timetable.

In Trusts C and E, all trainees were able to attend at least 50% of sessions with almost a third of trainees in Trust C achieving attendance at over 75% of sessions. In Trust B however 40% of respondents reported attending less than half of the regional teaching sessions and in 4 hospital sites (B, E, F and I) 47%, 33%, 50% and 50% of trainees respectively attended less than 50% of available regional teaching sessions, above the regional figure of 13% (Figure 14).

Figure 13: Attendance at Regional Teaching by Trust

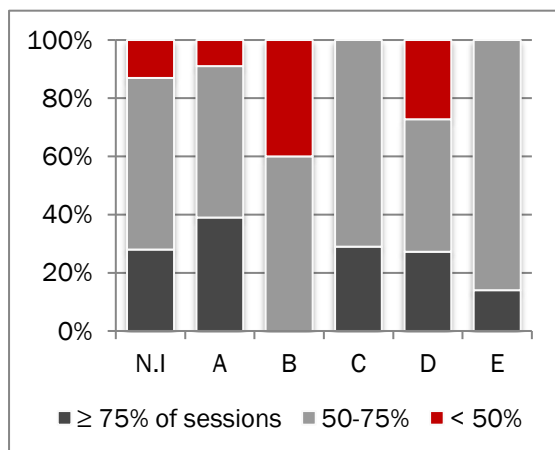
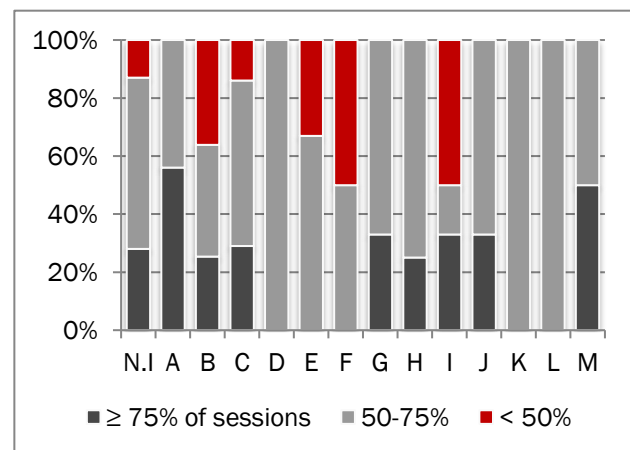


Figure 14: Attendance at Regional Teaching by Hospital site

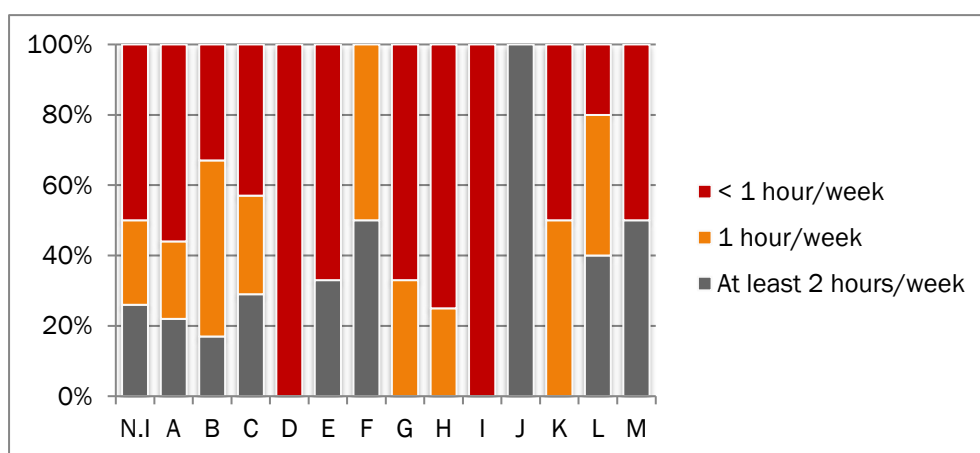


The main barriers to attendance at Regional Teaching were reported as: Rostered off days/pre and post nights (48%); working a long day (71%); commitments other than on-call in base unit (33%) and clinical activities running late (42%).

Local Departmental Teaching

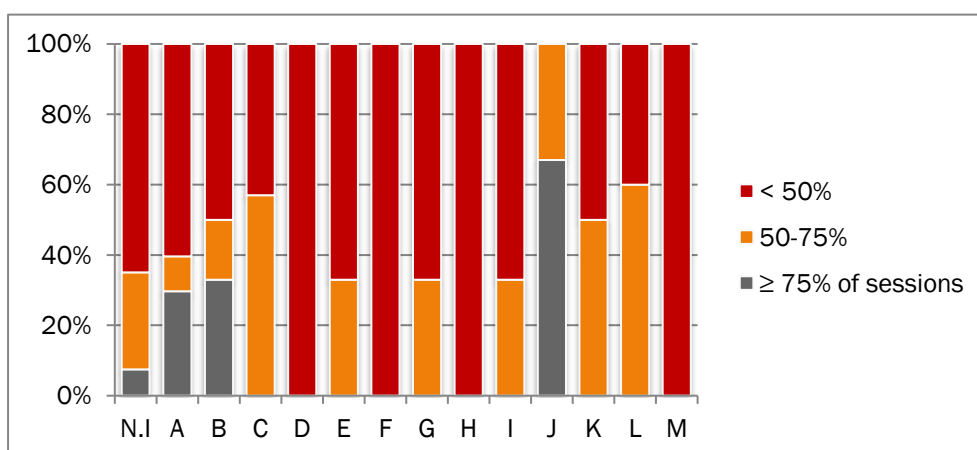
Regionally, only 26% of trainees reported receiving at least 2 hours of facilitated local teaching per week (e.g. departmental teaching, journal clubs, M&M meetings etc.) with 24% of respondents receiving just 1 hour per week and a further 50% less than 1 hour per week (Figure 15). In addition 61% of respondents reported being able to attend less than 50% of available local teaching sessions (Figure 16)

Figure 15: Protected Teaching by hospital site

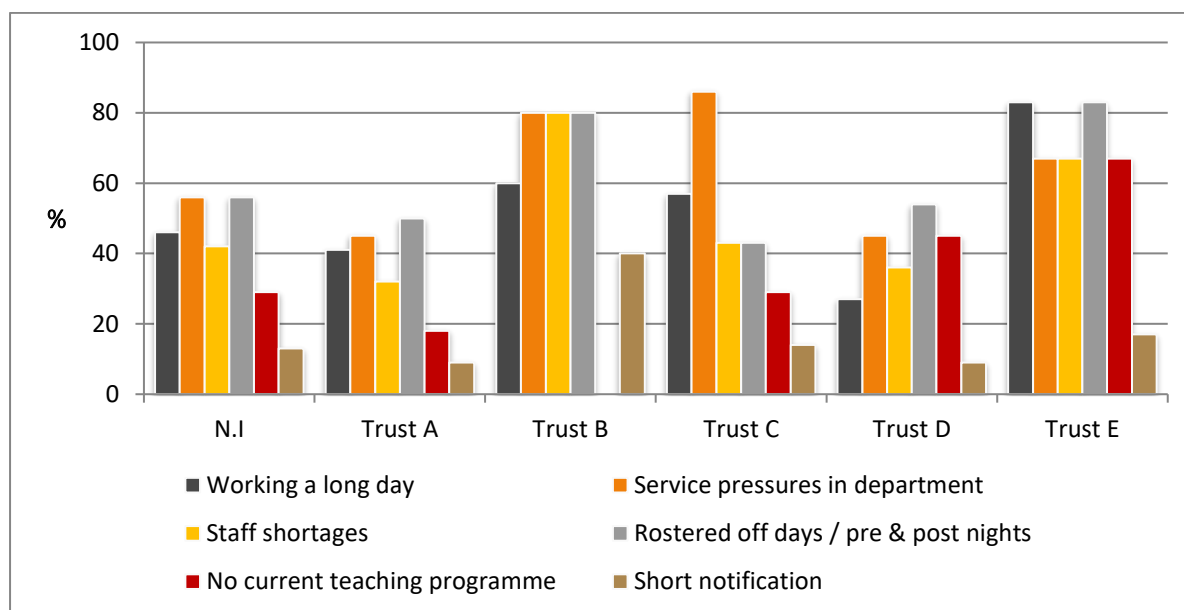


The results were above the regional average in hospitals F and M and in hospital J with 50% and 100% of trainees respectively indicating that they had received the recommended 2 hours of facilitated local teaching per week. In hospital J where all trainees received over 2 hours of teaching per week the provision of a dedicated and protected half day local teaching session was noted. In 8 of the 13 hospital sites, at least 50% of trainees reported receiving less than 1 hour per week of local teaching, and in hospitals E and G this was over two thirds. It was noted that in hospitals D and I, all trainees reported attending less than 1 hour per week of local teaching

Figure 16: Attendance at Local Teaching by hospital site

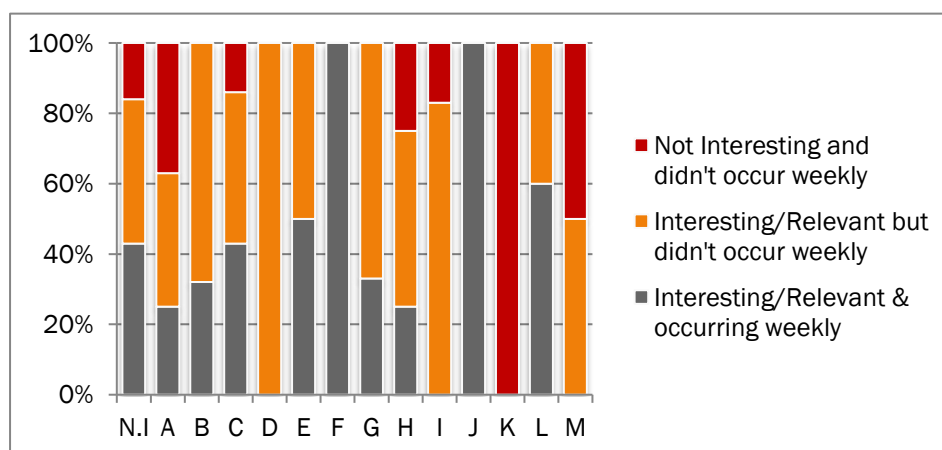


Barriers to attendance at local teaching were reported regionally as: Service pressures in department (56%); Staff shortages (42%); Rostered off (56%); On-call -working a long day (46%). (Figure 17)

Figure 17: Barriers to attendance at Local Teaching by Trust

Regionally, the quality of departmental teaching was rated as interesting and relevant by 84% of respondents, however only 43% reported that departmental teaching occurred weekly. A further 16% of respondents rated departmental teaching as neither interesting nor relevant and not occurring weekly (Figure 18).

There was variation in results between hospital sites, with the results from hospitals F, J and L, being well above the regional average, with 100%, 100% and 60% of respondents respectively reporting teaching as interesting/relevant and occurring weekly. In contrast, in hospitals K and M, 100% and 50% of respondents respectively indicated that departmental teaching was not interesting and was not occurring weekly.

Figure 18: Quality of Local Departmental teaching by hospital site

Good consultant attendance at local teaching (always/usually present) was reported by 57% of trainees regionally and in hospitals E, F, J and M, consultant attendance at local teaching sessions was reported by 100% of respondents, well above the regional figure.

Trainee Free Text Comments:

'Only 3 teaching sessions have occurred over the last 9 months. There are no departmental teaching and we are not told about M+M' (Site I)
'Uninterrupted teaching every Wednesday morning' (Site J)
'There is no allocated hospital based teaching. On occasion there is a drug rep meeting but this isn't trainee teaching' (Site K)
'1 hour on Friday morning for grand round presentations. Not protected and still received bleeps about non urgent clinical tasks' (Site B)
'1hr teaching per week which we often could not attend due to ward duties. Teaching provided on rota of 5 SHOs/ occasional other speakers' (Site C)
'Virtually zero teaching or training' (Site A)

Key Recommendations: Regional and Local Teaching

There has been an ongoing commitment to regional teaching through the development and delivery of a virtual online programme in the face of restricted face to face training opportunities. Regional attendance is being facilitated as evidenced by trainee feedback across all Trusts.

Regionally there is a lack of regular local teaching and a number of barriers to trainee attendance of which service pressures and staff shortages appear to contribute significantly. There is a need to reinstate local teaching programmes in sites where this has been stopped due to service pressures; to ensure provision of weekly teaching sessions; to increase trainee awareness/improve communication of the local training opportunities and to facilitate/'ring fence' trainee attendance .

All training units should deliver a weekly teaching programme

Trainees should have protected time to attend local departmental teaching

5. Training Opportunities (TOs)

Capabilities in Practice (CiPs)

There are 14 CiPs in the IMT curriculum ⁽¹⁾ which reflect the professional tasks, work, knowledge, skills and attitudes which should be demonstrated by an IMT Stage 1 doctor. There are 6 generic capabilities: which cover the universal requirements of all specialities and 8 clinical capabilities: clinical tasks or activities essential to the practice of IM.

Generic and Clinical CiPs: Access to TOs

Regionally good access to training opportunities is reported in the majority of domains with over 75% of trainees indicating access sufficient to meet training needs in 8 out of the 14 key training areas (Appendix 4A). In the remaining 5 areas over half of all trainees reported enough TOs to meet their training needs.

Access to training opportunities across the majority of hospital sites mirrored the regional results but it is noted in hospital K that access to TOs for clinical CiPs was limited with not enough training opportunities to meet training needs reported in 5 of the 8 key training areas (Appendix 4B). This result is felt to reflect the patient profile and recognised level of acute care on this site.

Insufficient opportunities to meet the training requirements in 'QI in patient care' were observed in hospitals D, J and L and regionally trainees reported not being able to set up a QI project in their post in 7 of hospital sites (Appendix 2B). It was noted however that during the survey period a COVID derogation was in place, removing the requirement for a QiP to be completed in the 2020/21 academic year, making the significance of the result uncertain. Access to TOs for 'Research and Data Management' was also reported as limited by the majority of trainees in hospitals D, G, H, J and L. Regionally it was noted that this was the lowest performing domain with just over half of trainees reporting sufficient access to training opportunities to meet their training needs.

Generic and Clinical CiPs: Quality of TOs

In 5 key areas (5 of the 8 Clinical CiPs), two thirds of trainees reported the quality of training as excellent or good and occurring at every/most attendances (Appendix 4C). Regionally in 9 of the 14 key training areas (Functioning within NHS organisational and management systems; Dealing with ethical & legal issues related to clinical practice; Communication & Decision making; Patient safety and QI in patient care; Research & Data Management; Acting as a Clinical Teacher and Clinical Supervisor; Managing an acute unselected take; Managing outpatients with long term conditions and Managing medical problems in patients in other specialities and special cases); almost half (40-50%) of trainees reported that while good training occurred occasionally, TOs were often or regularly missed.

The quality of training in the area of research and data management was poor across the majority of hospital sites with only a third of trainees indicating that training was excellent/good and occurring regularly.

There was considerable variation in the quality of training reported between hospital sites (Appendix 4C). In hospital sites K and M results were significantly below both the Trust and Regional figures in all or the majority of the 14 key areas; with the respondents reporting that training opportunities are regularly missed. In hospital K this is mitigated in part by the lack of TOs reported in 6 of the 14 domains, but in the remaining 8 domains, despite good access to TOs being reported, trainee feedback is that TOs are being regularly missed.

Practical Procedures

Access to Training Opportunities

There are a number of procedural skills set out in the JRCPTB Curriculum for Internal Medicine, in which a trainee must become proficient to the level expected by the end of IM stage 1 ⁽¹⁾.

Regionally a significant lack of training opportunities is reported in the majority of key practical procedures with less than a third of trainees reporting adequate training opportunities to acquire practical skills in 6 of the 12 key areas of the curriculum (Appendix 5A).

Areas where there was most difficulty in getting TOs to acquire the necessary practical skills were in: Temporary cardiac pacing using an external device; Central venous cannulation; Pleural aspiration for fluid (diagnostic); and Pleural aspiration and Intercostal drain for pneumothorax, where over 60% of trainees reported too few training opportunities.

Across all Trust sites, the access reported to training opportunities in the majority of key practical procedures, closely mirrored the regional findings (Appendix 5B). There were a few noted variations. In hospitals B, E, G, H, I, L and M access to TOs for Ascitic tap and abdominal paracentesis were above the regional figures and were reported by the majority of trainees as sufficient to meet their training requirements. In hospitals E, F, I, J and M between two thirds and 100% of trainees reported good access to TOs for Direct (DC) cardioversion; significantly above the regional figure of 36% and in hospital I 50% of trainees reported good access to TOs in Pleural aspiration for fluid (diagnostic) and for pneumothorax, well above the regional figures of 13% and 15% respectively.

In hospital K all trainees indicated not enough TOs in all the key practical procedures; again this likely reflects the non-urgent care predominately delivered on this site.

It should be noted that not all practical procedures are available on each site or during each placement (e.g. TOs for central venous cannulation and DC cardioversion usually obtained during ICU/cardiology rotations) and this needs to be considered when interpreting the results for each site.

Quality of Training Opportunities

Regionally, for 7 of the 12 mandated practical procedures, over two thirds of trainee reported that TOs were often or regularly missed with less than a third of trainees reporting training as excellent or good and occurring at all or most attendances (Appendix 5C). This appears to correlate in most cases to those practical procedures where trainee feedback had indicated that access to training opportunities (TOs) was limited.

Across the majority of sites, the overall impression given by the PQ survey results is that when training opportunities for practical procedures occur, the quality of training delivered is good; however across the majority of mandated practical procedures, training opportunities are often being missed.

There is again considerable variation in site results (Appendix 5D). In hospitals A, B, G, I, J and L between half and two thirds of trainees indicate excellent/good training in Ascitic taps and in sites A, G and I for abdominal paracentesis, above the regional figures in which around two thirds of trainees indicate TOs are often or regularly missed. Training in lumbar puncture is reported as good by the majority of respondents in hospitals A, B, G, H, I, J and L and in hospital A, E, F and L, between half and two thirds of trainees report excellent or good training occurring at all or most attendances in DC cardioversion.

In hospital K, where all trainees had indicated not enough TOs in the key practical procedures; ALL trainees reported that training opportunities usually didn't occur. In hospital M however where good access to TOs in 9 of the mandated practical procedures was reported, feedback on the quality of training was poor, with ALL respondents indicating that training was often/regularly missed or rarely occurred.

Trainee Free Text Comments

'There is just in general a real lack of training opportunities. I definitely feel like a service provider and to be honest, there is no difference at all between job description for internal medicine trainees and F2s, which is a real shame. There should definitely be a difference in responsibilities i.e. attending clinics or the acute care unit for 1 session a week to gain training or procedural experience; or even a session per week set aside for IMTs to complete QI projects' (Site A)

'Often training opportunities are missed in the context of managing medical inpatients as in this job, registrars primarily carry out daily reviews and are involved in daily management of neurology inpatients, while the SHOs primarily provide support with bloods/discharge letters/referrals/cannula. This is due mainly to the absence of FY1 support in this post' (Site A)

'There were not any formal training sessions. Training/feedback received depended entirely on the supervising consultant. Some were excellent at this and very helpful. Others were not at all' (Site M)

'Pressure from work tasks means that efficiency takes over and training is not prioritised' (Site I)

'Very few opportunities. Often very few staff who can perform the procedures. Ward pressure often means there is no time to attend OP hubs to do the procedures' (Site I)

'There wasn't really a training culture, certainly not any formal training and the nature of the small hospital meant very limited exposure to many aspects of medicine. Lack of training may be down to high of locum docs. Not really a suitable environment for an IMT as the emphasis on IMT is supposedly 'acute medicine' (Site K)

'No formal training at all, did a patient need any practical procedures and if they did they were usually transferred elsewhere for management. No opportunity even for a simulation training program. No registrars to teach procedures or advanced CPR etc.' (Site K)

'No opportunities to do any practical procedures' (Site K)

'Quite a lot of procedures done for inpatients but due to pressure on staffing level and workload training are always missed' (Site F)

'Practically these procedures rarely occur in practice. No simulated experience in my time here' (Site H)

'Very little training opportunities provided for generic skills such as data management, QI and leadership. Although such topics are offered regionally via NIMDTA; locally needs to work more on developing this type of teaching for trainees' (Site H)

'Very few procedures happening' (Site E)

'Not acute site therefore practical procedures don't take place here'

'No opportunity to perform procedures due to patient demographics; most patients are managed as outpatients.' (Site C)

'Most of these procedures didn't regularly occur in my current post and those that did often I didn't get to attend due to staffing issues' (Site B)

Key Recommendations: Generic & Clinical CiPs and Practical Procedures

Regionally it is noted that most hospital sites during the period of the survey were operating with an increased level of unscheduled care and at above normal levels of bed occupancy. The ability of lead educators and trainers to ensure training continued with good access to training opportunities in these circumstances is to be commended.

Regionally there is a need to increase and maximise the use of available training opportunities for practical procedures; to increase where possible the use of SIM based methods to deliver training for the less commonly occurring procedures and to increase trainee awareness of the training opportunities offered during their placement to provide realistic expectations of what can and should be achievable in their post.

Trainees to be made aware of the available TOs for practical procedures at the start of each placement

Increased use of SIM based training modalities to deliver less commonly occurring practical procedures

Outpatient Clinics (OPCs)**Access to Training Opportunities**

Limited access to OPCs was reported regionally, with only 50% of trainees reporting sufficient access to OPCs to meet their training needs (Table 1). A significant number of trainees reported having attended less than 10 face to face or virtual OPCs (57% and 76% respectively). Overall, 15% of trainees reported having attended **no** face to face OPCs and 36% **no** virtual OPCs.

Good availability of consultant supervision was however reported regionally with 84% of respondents indicating that consultant supervision was available at all clinics.

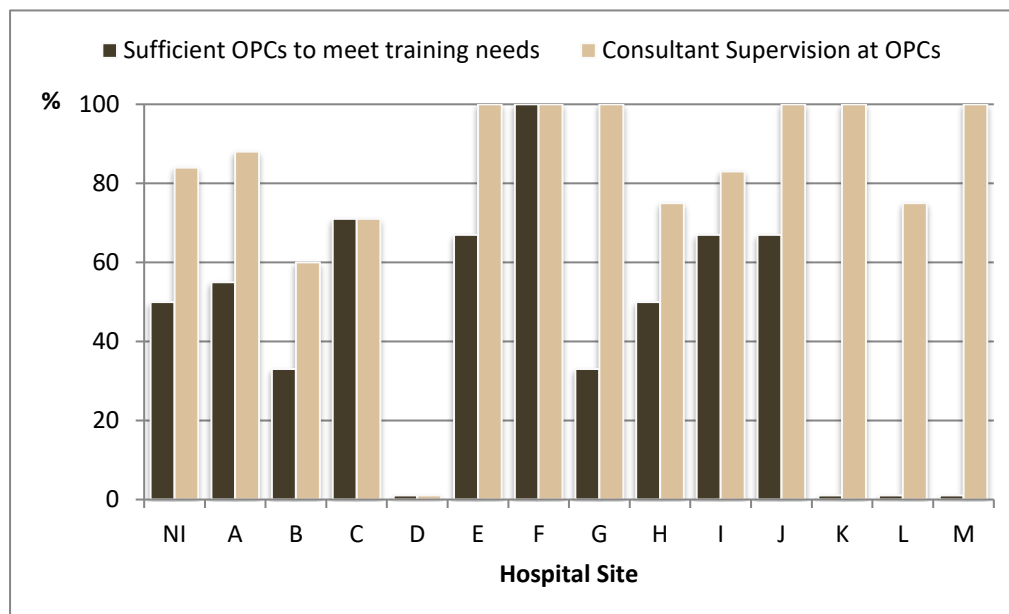
Table 1: Regional Access to OPCs

Outpatient Clinics: Access & Supervision (Regional)	N.I 2021 Regional
Access to enough OPCs to meet training needs : Yes	50%
Face to face OPCs	
Number of face to face OPCs attended: >20	23%
Number of face to face OPCs attended: 11-20	19%
Number of face to face OPCs attended: 1-10	42%
Number of face to face OPCs attended: None	15%
Virtual OPCs	
Number of virtual OPCs attended:>20	13%
Number of virtual OPCs attended: 11-20	10%
Number of virtual OPCs attended: 1-10	40%
Number of virtual OPCs attended: None	36%
Consultant Supervision available at all clinics	84%

Access to OPCs varied between hospital sites. In hospitals C, E, F, I and J over two thirds of trainees reported sufficient access to OPCs to meet their training needs (Table 2). In hospitals B and G this was only a third of trainees and in hospitals D, K, L and M **all** trainees reported not enough access to OPCs. It

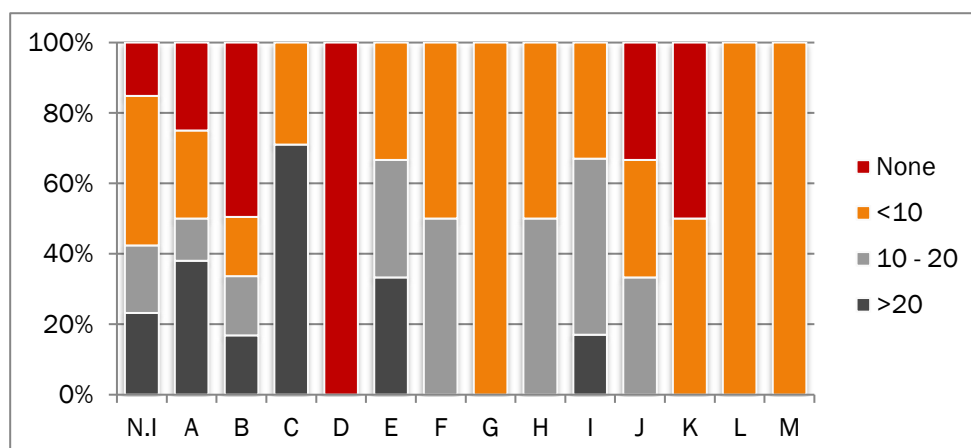
was noted that in hospitals B and D, trainees in a number of posts do not routinely attend OPCs which will have affected the survey results for these sites.

Table 2: Access to OPCs and consultant supervision by hospital site



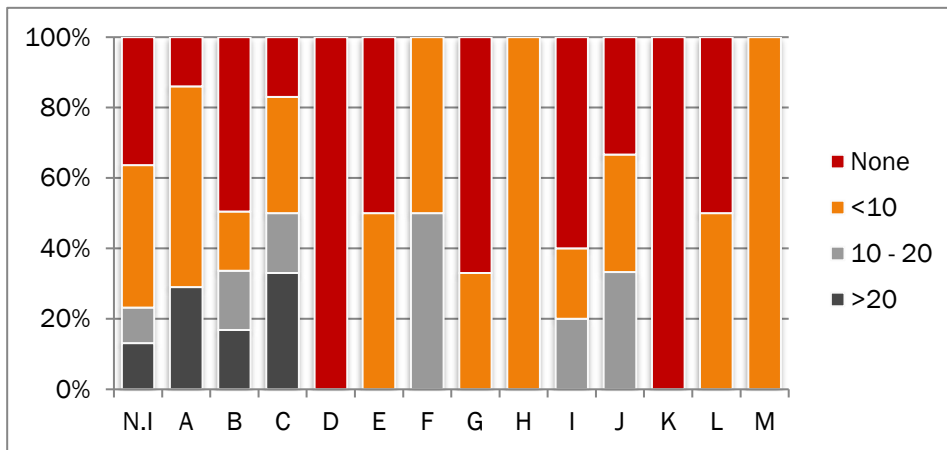
In hospitals C, E and I attendance at face to face OPCs was above the regional average with at least two thirds of trainees on these site reporting sufficient access to OPCs to meet their training needs (Figure 19). In hospital sites D, G, K, L and M however all trainees reported being able to attend less than 10 OPCs and in sites D and K 100% and 50% of trainees respectively reported having attended no OPCs; significantly below the regional figure.

Figure 19: Access to face to face OPCs during placement by hospital site



During the period of the survey, it was recognised that there was a reduced level of outpatient activity, specifically face to face clinics, across most Trust sites due to the ongoing COVID pandemic; for this reason trainees were also asked about attendance at virtual OPCs (Figure 20). Attendance at virtual OPCs was as expected lower than for face to face clinics with trainees in most hospitals having access to less than 10 or no virtual clinics. It is noted that in hospitals A, B and J and in sites C and F, a third and 50% of respondents respectively indicated access to at least 10 virtual clinics and in sites A and C around a third of trainees had access to over 20 virtual OPCs, above the regional figure of 13%.

Figure 20: Access to virtual OPCs during placement by hospital site



Trainee Free Text Comments

'Clinic weeks cancelled due to pandemic' (Site E)

'Unable to attend clinic due to ward staff shortage' (Site H)

'Few clinics due to pandemic' (Site I)

'Due to staff shortages and a lot of consultant led virtual clinics, I was unable to attend enough clinics' (Site J)

'Did not have protected time. No allocation time for clinic/procedures. I think the training post should accommodate and address our compulsory training curriculum-procedure/clinics and not just a service provider' (Site B)

'Was not factored into our Rota and at induction we were advised to book study leave if we wished to attend clinic' (Site B)

'Very few outpatient clinics, with none involving in person assessment' (Site A)

'Often scheduled for clinic but unable to attend due to staff pressures on ward' (Site C)

'Clinic weeks cancelled due to pandemic' (Site L)

'I got to 2 clinics during my placement and that was only for an hour or so before having to go back to the ward' (Site M)

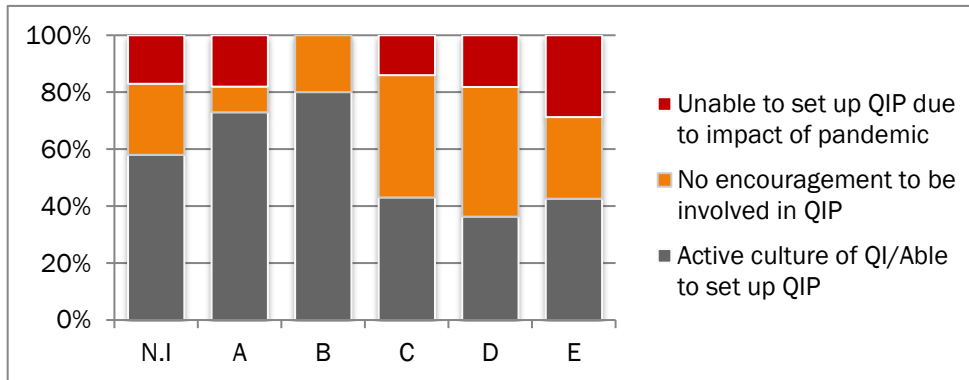
Quality Improvement Projects (QIP)

Access to Training Opportunities for QIPs

Regionally 58% of trainees reported an active culture of QI within their post and the ability to set up a QIP as required in the IMT curriculum (Figure 21). In Trust B it is noted that 80% of trainees reported an active culture of QI within their post and the ability to set up a QIP as required in the IMT curriculum; well above the regional figure of 58%. In addition no trainee this site reported being unable to set up a QIP due to the pandemic.

In Trusts A, C, D and E however, 18%, 14%, 18% and 29% of trainees respectively indicated being unable to set up a QIP due to the impact of the pandemic and in Trusts C, D and E just over a third of trainees reported no encouragement to be involved in a QIP. It is noted that during the survey period, a COVID derogation was in place, removing the requirement for a QIP to be completed in the 2020/21 academic year, which may have influenced the lack of QIP involvement reported in a number of sites.

Figure 21: Involvement in QIPs by TRUST



Key Recommendations: OPCs and QIPs

Trainee attendance at OPCs should be scheduled on the rota

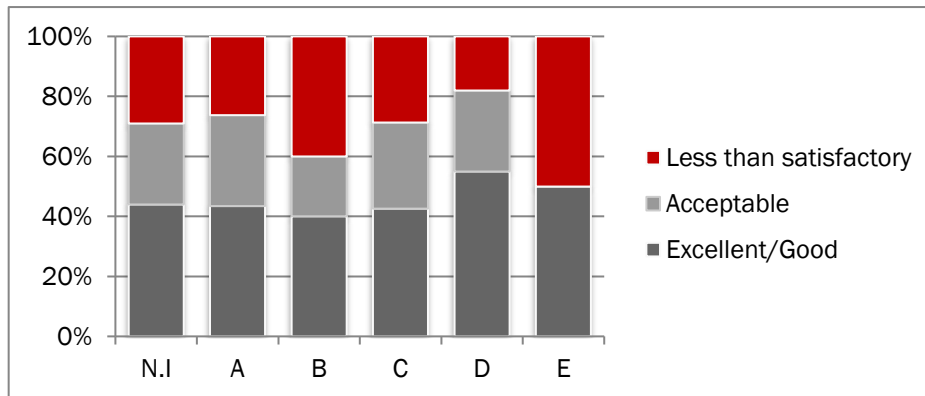
All trainees should have the opportunity to be involved in a QIP

6. Overall Opinions and Suggestions for Improvement

Overall Opinions

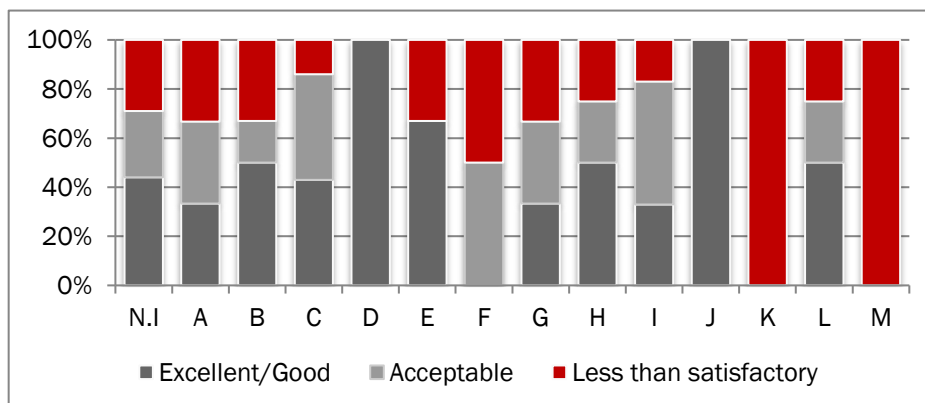
Feedback from trainees was largely positive across a wide range of areas surveyed and this is reflected in the overall global score for placements, where regionally 71% of respondents rated the training opportunities provided by their current placement as acceptable and 44% as either excellent/good (Figure 22).

Figure 22: Global Score for placement as a training opportunity By TRUST



In hospitals A, B, E, G, H and L around a third of trainees reported the placement as less than satisfactory, in line with the regional figure of 29% (Figure 23). Above average results were noted in hospitals D and J where all trainees rated their placements as either /good as a training opportunity. In hospital K and M however all respondents reported their placement as less than satisfactory.

Figure 23: Global Score for placement as a training opportunity by hospital site



Summary of Trainee Suggestions for Placement Improvement

- Recommending regular teaching and training as COVID pressure begin to ease
 - Trainee comment '*Provision of training is not optional*'
- More regular teaching and training/ Dedicated training days / Organised SIM training
- More focus on trainee needs e.g. procedural requirements, clinics
- More opportunities for mandatory procedures
- Mandatory clinic weeks allocated in the rota
- Protected time for outpatient clinics
- Better support for involvement in clinical research/posters/presentations/ QI /case reports at hospital level
- Adequate ward staffing
- Priority given to training grade doctors for completion of procedures and WPBAs

2: Good Practice and Actions Identified (Trust)

Rota Allocation

There is a requirement for Trusts to inform trainees of their out of hours (OOH) rota allocation within 6 weeks of the commencement of their post. ⁽³⁾

Good Practice

- 1) Establishment of a multidisciplinary working group to look at all aspects of the induction process including rota allocation. ^(B)
- 2) Distribution of the OOH rota template 6 weeks before post commencement to all confirmed placements. ^(B)

Induction

Good Practice

- 1) Establishment of a multidisciplinary working group to look at all aspects of the induction process including rota allocation. ^(B)
- 2) Provision of online induction materials. ^(A, B, C, D, E)
- 3) Provision of an online medical specialty handbook ^(C)
- 4) Post induction follow-up meeting, 2- 4weeks after post commencement to clarify outstanding questions.^(C)

Proposed Trust Actions:

- 1) Trust to reintroduce face to face component to induction alongside online component. ^(A, B, C, D, E)
- 2) Compilation of an online video bank of 'How to' videos by consultants on key induction related topics/areas of working practice. Will facilitate delivery of inductions which occur out of sync in IMT rotations. Videos to be made available on the Trust Medical Education platform. Available Feb 2022. ^(C)
- 3) Development of an Induction 'Page Tiger' for all specialties including IMT. Will provide 'live' attachments with auto updated guidelines to supplement Trust and 'New to NI' information already in place. Available August 2022. ^(D)
- 4) Appointment of a Lead for Education in Medical Specialties with responsibility for co-ordinating/organising induction. ^(D)

Educational Supervision, Clinical Supervision and Feedback

Good Practice

- 1) Evidence of an ongoing commitment to deliver high quality educational and clinical supervision across all training units in the School of Medicine ^(All Trusts)

Proposed Trust Actions

- 1) Education leads to raise trainer awareness of feedback opportunities and to increase trainee recognition of informal feedback. ^(All Trusts)

Clinical Workload

Good Practice

- 1) Trust has expanded the hospital at night and phlebotomy services to aid the OOH workload. ^(E)

- 2) A trainee feedback forum has been established in which trainees are asked to provide feedback to the Trust as to which areas of practice extra resources need to be put into. This forum meets once a month. ^(E)
- 3) Trust has funded three new IMT posts. ^(G)
- 4) Trust has undertaken a number of measures to try to alleviate staff shortages: increased the number of PAs (Physician Assistants) within the Trust; recruited an additional 10 Clinical Fellows; increased the number of prescribing pharmacists on the wards and in conjunction with QUB has facilitated medical student technicians on site at the weekend to help carry out practical procedures ^(G)
- 5) Trust planning to recruit additional medical consultants and has requested allocation of an additional IMT trainee from NIMDTA. ^(G)
- 6) Trust employing a virtual rota management system - the Doctors Hub, delivering a proactive approach to rota management. The package has input from both support staff and clinicians and offers flexibility; allowing trainees to manage their rota (e.g. change shifts, swap nights). ^(L)

Proposed NIMDTA/School of Medicine Actions:

- 1) The School of Medicine is to review the senior trainee allocations to hospital F for 2022.

Regional and Local Teaching

Good Practice

- 1) Dedicated and protected half day of formal facilitated teaching available each week ^(J)
- 2) Consultant led structured local teaching programme; 6 month programme emailed to all trainees at start of placement ^(I)
- 3) Teaching programme in place for MRCP (PACES) teaching: sessions held out of hours and runs 2-3 times per year (Trust A)
- 4) Trust using a text system to provide regular information to trainees about planned teaching sessions ^(E)
- 5) Consultant delivered IMT specific teaching being delivered during lunchtime 3 days per week ^(G)
- 6) Local teaching is being uploaded to the Trust's digital platform and is accessible to all IMTs through the Medall system (Medall.org) ^(G)
- 7) Regular teaching provided on OSCE/SIM based topics – programme planned over 12 months ^(G)

Proposed Trust Actions:

- 1) Trust to reinforce to educational leads the need to increase trainee awareness of the local teaching available. ^(All Trusts)
- 2) Trust to widen communication of scheduled local teaching. ^(I)
- 3) Trust setting up MS Teams to help provide information and encourage attendance at available teaching sessions ^(E)
- 4) Trust exploring expansion of available education space/teaching facilities ^(I)

Proposed NIMDTA Actions:

- 1) Deputy Head of School of Medicine to ensure Trust notification of the regional teaching dates.

Training Opportunities

Good Practice

- 1) For practical procedures where TOs are limited, trainees are given details of the consultant to be contacted to organise specific training. IMT trainees are given priority for these types of limited opportunities ^(A)

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- 2) Signposting trainees not on a cardiology rotation to the consultant in the catheterisation lab on the morning when DCCs are scheduled, to facilitate exposure and sign off for this procedure ^(G)
- 3) IMT trainees given priority in booking places on the IMPACT course ^(G, L)
- 4) Chest drain course held 6 times per year which IMT trainees can access ^(L)
- 5) Development of an innovative way to allow IMTs access to OPCs in face of a reduction in clinic numbers (Consultant attends OPC face to face and IMT joins virtually using zoom platform; allows trainees to ask questions and maximises training opportunities). ^(H)
- 6) IMT trainees prioritised for attendance at OPCs to ensure delivery of curriculum requirements ^(E)
- 7) Annual Trust wide competition for the best QiP to encourage trainee involvement on research and QiP. Trust holds an annual medical award evening. ^(Trust B)
- 8) Annual Prize for research /QiP. Trust has an Identified research lead. ^(Trust C)
- 9) Trust Lead for Research and Innovation appointed. ^(Trust D)
- 10) 'Understanding Evidence' education module and Trainee Research Day delivered annually ^(NIMDTA)
- 11) iQuest QI module developed by School of Medicine

Proposed Trust Actions

- 1) Trust through lead educators to increase trainee awareness of the availability of training opportunities for practical procedures. ^(Trust A)
- 2) Trust to consider how SIM could be used to deliver some of the mandated procedural skills ^(Trust A)
- 3) Development of a new lumbar puncture and Ascitic tap course for trainees unable to attend the IMPACT course to facilitate procedure sign off ^(G)
- 4) Reintroduction of clinic weeks to facilitate IMT training needs ^(L)
- 5) Trust working with Education fellows to develop and introduce a 'clinic week' by February 2022 ^(G)
- 6) Trust working to develop and provide a number of academic/research medical posts to increase opportunities for trainee involvement in research and QiP. ^(Trust C)
- 7) Trust planning to advertise a number of academic research posts – with an emphasis on educational research. ^(L)
- 8) Trainee awareness of QiP and Research opportunities to be raised. ^(ALL Trusts)

Proposed NIMDTA/School of Medicine Actions:

- 1) The School to review those mandated practical skills that can be signed off with skills lab exposure, as defined in the curriculum and consider a regional approach to delivering simulation in these areas (Temporary cardiac pacing using an external device; Central venous cannulation (internal jugular or subclavian) ; Access to circulation for resuscitation (femoral vein or intraosseous); Intercostal drain for pneumothorax and Intercostal drain for effusion - Skills lab or satisfactory supervised practice)

Others

Good Practice:

- 1) Use of a virtual rota management system – 'Doctors' Hub', providing a proactive approach to rota management. The package has input from clinicians and support staff and offers flexibility; allowing trainees to easily manage their rota at home as well as in work, facilitating changes of shifts, nights etc. ^(E)

Summary of Report Recommendations

- 1) All trainees, in addition to online information, should have a face to face induction to their department/unit and receive clear guidance on their specific roles and responsibilities
- 2) Trusts should provide all trainees with information of their OOH rota at least 6 weeks prior to post commencement
- 3) Clinical supervisors /consultant trainers should provide informal feedback to all IMT trainees at least a few times a month
- 4) All training units should deliver a weekly teaching programme
- 5) Trainees should have protected time to attend local departmental teaching
- 6) Trainees to be made aware of the available training opportunities for practical procedures at the start of each placement
- 7) Increased use of SIM based training modalities to deliver less commonly occurring practical procedures
- 8) Trainee attendance at OPCs should be scheduled on the rota
- 9) All trainees should have the opportunity to be involved in a QiP

References

- 1) JRCPTB: Curriculum for Internal Medicine Stage 1 Training [Internal Medicine stage 1 curriculum FINAL 221217.pdf \(jrcptb.org.uk\)](#)
- 2) BMA [Code of Practice Section 6.1: Employment Information](#)
- 3) [GMC Promoting Excellence](#): standards for medical education and training. (2016)

APPENDIX 1: Targets and Colour coding for PQ Survey Education Areas/Tables

Education Areas	Targets (% of trainees attaining target)
TRUST notification of on-call rota > 4 weeks (Q.9)	100%
Induction appropriate (Q.11)	100%
Workload (Daytime) Just Right (Q.17)	≥50%
Workload (Long Day) Very Intense/Excessive (83/17%)	≤50%
Workload (Night) – Very Intense/Excessive (67/33%)	≤50%
Workload (Weekends) – Very Intense/excessive (67/17%)	≤50%
Good support from senior trainees (when workload excessive) (Q.18)	≥75%
Good support from consultant (when workload excessive) (Q.19)	≥75%
Attendance at Regional Teaching (Q.20) - 50% or more sessions	≥50%
Able to attend MRCP exam preparation teaching sessions (Q.23)	≥50%
Protected local teaching: At least 2 hrs/week (Q.24)	≥50%
Protected local teaching: 1 hr/week	100%
Protected local teaching: Less than 1 hr/week	0%
Local Teaching: Consultant attendance - Always/Usually (Q.28)	100%
Critical Appraisal & Research – active culture (Q.30)	≥50%
Able to set up a QIP (Q.31) - (yes)	100%
Educational Supervision - Satisfactory (Q.33)	≥90%
Clinical Supervision (Day time) - Acceptable (Q.34).	≥90%
Clinical Supervision (OOH) – at least Acceptable (Q.35)	≥90%
No difficulty getting WPBAs needed for progression (Q.36)	≥90%
Feedback:(Q.37) At least once a month	100%
Feedback: Less than once a month	0%
OVERALL Satisfaction: Placement rated as At least acceptable	100%
OVERALL Satisfaction: Placement rated as Less than satisfactory/Poor	0%

EDUCATION AREAS

Colour coding for data tables:

NI Regional Data		Trust Data	
Target achieved	Below Target	Figures 10% or more above/better than the regional figures	Figures 10% or more below/worse than the regional figures

* All Trust results which achieve the set targets are marked with an asterisk and the cell highlighted *

Target achieved by Trust *	Target achieved by Trust * Figures 10% or more above/better than the regional figures	Target achieved by Trust * Figures 10% or more below/worse than the regional figures
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GENERIC & CLINICAL CiPs

Targets and Colour coding for ACCESS to Training Opportunities (TOs)

ACCESS to TOs sufficient to meet training needs % of trainees			
≥ 50%	≥ 75%	≤ 50%	≤ 30%

Targets and Colour coding for QUALITY of Training Opportunities

QUALITY of TOs (Excellent/Good and occurring at most attendances) - % of trainees			
≥ 50%	≥ 75%	≤ 50%	≤ 30%

PRACTICAL PROCEDURES

Targets and Colour coding for ACCESS to Training Opportunities (TOs) in PRACTICAL PROCEDURES

ACCESS to TOs sufficient to meet training needs - % of trainees			
≥ 50%	≥ 75%	≤ 50%	≤ 30%

Targets and Colour coding for QUALITY of Training Opportunities in PRACTICAL PROCEDURES

QUALITY of TOs (Excellent/Good and occurring at most attendances) - % of trainees			
≥ 50%	≥ 75%	≤ 50%	≤ 30%

APPENDIX 2A: EDUCATION AREAS - SURVEY RESULTS BY TRUST

EDUCATION AREAS	N.I Regional	TRUST A	TRUST B	TRUST C	TRUST D	TRUST E
TRUST notification of on-call rota > 4 weeks (Q.9)	61%	65%	100%*	43%	36%	73%
Induction appropriate (Q.11)	65%	78%	60%	43%	55%	57%
Impact of rota gaps on day to day training – No impact	28%	27%	0	14%	20%	50%
Impact of rota gaps on day to day training –Increased Workload/Missed TOs	52/35%	41/32%	100/25%	57/43%	60/30%	17/33%
Impact of rota gaps on day to day training –Difficulty getting study /annual leave	28%	14%	0%	43%	50%	33%
Workload (Day-time) Just Right (Q.17)	65%	78%*	20%	71%*	55%	71%*
Workload (Long Day) Very Intense/Excessive (32/13%)	44%	13/4%*	20/40%	57/29%	55/9%	43/14%
Workload (Night) – Very Intense/Excessive (19/15%)	34%	13/0%*	20/40%*	0/43%	36/18%	33/17%
Workload (Weekends) – Very Intense/excessive (41/20%)	61%	30/13%	0/60%	57/43%	55/9%	57/14%
Good support from senior trainees (when workload excessive) (Q.18)	80%	76%	100%*	71%	100%*	67%
Good support from Consultant (Q.19)	74%	70%	80%*	71%	89%*	60%
Attendance at Regional Teaching (Q.20) - 50% or more sessions	87%	91%*	60%*	100%*	73%*	100%*
Protected local teaching: At least 2 hrs/week (Q.24)	26%	22%	40%	0%	27%	43%
Protected local teaching: 1 hr/week	24%	30%	20%	29%	9%	29%
Protected local teaching: Less than 1 hr/week	50%	48%	40%	71%	64%	28%
Local Teaching: Consultant attendance - Always/Usually (Q.28)	58%	48%	100%*	43%	50%	86%
Critical Appraisal & Research – active culture/ encouraged to participate (posters/presentations/research) (Q.30)	28%	30%	50%*	14%	18%	29%
Able to set up QI/ Active culture of QI (Q.31) - (yes)	58%	73%	80%	43%	36%	43%
Educational Supervision - Satisfactory (Q.32) (NI: Excellent/Above average: 68%)	91%	100%* (83%)	100%* (60%)	100%* (86%)	73% (18%)	86% (86%)
Clinical Supervision (Day time) - Acceptable (Q.34) (NI: Excellent/Good: 50%)	94%	96%*	80%	100%*	90%*	100%*
Clinical Supervision (OOH) - Acceptable (Q.35) (NI: Excellent/Good: 33%)	94%	95%*	80%	86%	100%*	100%*
No difficulty getting WPBAs needed for progression (Q.36)	72%	70%	60%	71%	82%	71%
Feedback:(Q.37) At least a few times a month	33%	26%	60%	29%	30%	43%
Feedback: Once a month or less	67%	74%	40%	71%	70%	57%
OVERALL Satisfaction: Placement rated as Excellent/Good	44%	43%	40%	43%	45%	40%
OVERALL Satisfaction: Placement rated as Acceptable	27%	30%	20%	29%	27%	20%
OVERALL Satisfaction: Placement rated as Less than satisfactory/Poor	29%	26%	40%	28%	27%	40%

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APPENDIX 2B: EDUCATION AREAS - SURVEY RESULTS BY SITE

EDUCATION AREAS	NI Regional	SITE A	SITE B	SITE C	►SITE D	SITE E	SITE F
TRUST notification of on-call rota > 4 weeks (Q.9)	61%	78%	67%	43%	*100%	*100%	*100%
Induction appropriate (Q.11)	65%	89%	83%	57%	*100%	33%	*100%
Impact of rota gaps on day to day training – No impact	28%	43%	33%	29%	0%	0%	%
Impact of rota gaps on day to day training –Increased Workload/Missed TOs	52/35%	29/4%3	67/67%	71/14%	0/100%	100/0%	100/50%
Impact of rota gaps on day to day training –Difficulty getting study /annual leave	28%	14%	33%	14%	0%	0%	0%
Workload (Day-time) Just Right (Q.17)	65%	*78%	*67%	*86%	*100%	33%	0%
Workload (Long Day) Very Intense/Excessive	44%	*11/0%	*17/17%	*14/0%	*0/0%	*33%	100%
Workload (Night) – Very Intense/Excessive	34%	*33/0%	*0/0%	*0/0%	*0/0%	*33%	100%
Workload (Weekends) – Very Intense/excessive	61%	*33/11%	*17/33%	*43/0%	*0/0%	*33%	100%
Good support from senior trainees (when workload excessive) (Q.18)	80%	67%	*80%	*100%	*100%	*100%	N/A
Good support from Consultant (Q.19)	74%	67%	60%	*83%	No Data	67%	*100%
Attendance at Regional Teaching (Q.20) - 50% or more sessions	87%	*100%	*83%	*86%	*100%	*67%	*50%
Protected local teaching: At least 2 hrs/week (Q.24)	26%	22%	17%	29%	0%	33%	*50%
Protected local teaching: 1 hr/week	24%	22%	50%	28%	0%	0%	50%
Protected local teaching: Less than 1 hr/week	50%	56%	33%	43%	100%	67%	0%*
Local Teaching: Consultant attendance - Always/Usually (Q.28)	58%	44%	67%	33%	0%	*100%	*100%
Critical Appraisal & Research – active culture/ encouraged to participate (posters/presentations/research) (Q.30)	28%	44%	33%	14%	0%	0%	*100%
Able to set up QI/ Active culture of QI (Q.31) - (yes)	58%	88%	67%	71%	0%	67%	*100%
Educational Supervision - Satisfactory (Q.33) (Excellent/Above average)	91% (67%)	*100% (89%)	*100% (100%)	*100% (71%)	*100% (0%)	*100% (33%)	*100% (100%)
Clinical Supervision (Day time) - Acceptable (Q.34) (Excellent/Above average)	94% (51%)	89% (44%)	*100% (67%)	*100% (43%)	*100% (0%)	67% (33%)	*100% (50%)
Clinical Supervision (OOH) - Acceptable (Q.35) (Excellent/Above average)	94% (34%)	89% (33%)	*100% (67%)	*100% (14%)	*100% (0%)	*100% (33%)	50% (0%)
No difficulty getting WPBAs needed for progression (Q.36)	72%	67%	83%	71%	0%	60%	50%
Feedback:(Q.37) At least a few times a month	33%	22%	50%	14%	0%	67%	50%
Feedback: Once a month or less	67%	78%	50%	86%	100%	33%	50%
OVERALL Satisfaction: Placement rated as Excellent/Good	44%	33%	50%	43%	*100%	67%	0%
OVERALL Satisfaction: Placement rated as Acceptable	27%	33%	17%	43%	0%	0%	50%
OVERALL Satisfaction: Placement rated as Less than satisfactory/Poor	29%	33%	33%	14%	0%	33%	50%

EDUCATION AREAS	Regional	SITE G	SITE H	SITE I	SITE J	SITE K	SITE L	SITE M
TRUST notification of on-call rota > 4 weeks (Q.9)	61%	33%	50%	33%	67%	0%	80%	50%
Induction appropriate (Q.11)	65%	33%	50%	33%	*100%	50%	40%	*100%
Impact of rota gaps on day to day training – No impact	28%	0%	25%	*0%	*67%	*0%	75%	0%
Impact of rota gaps on day to day training –Increased Workload/Missed TOs	52/35%	67/33%	50/50%	*67/33%	*33/33%	*100/0%	0/0%	50/100%
Impact of rota gaps on day to day training –Difficulty getting study /annual leave	28%	0%	75%	*67%	33%	*0%	25%	50%
Workload (Day-time) Just Right (Q.17)	65%	33%	*100%	33%	*100%	*50%	*80%	*50%
Workload (Long Day) Very Intense/Excessive	44%	100%	75%	100% (83/17)	*33% (33/0)	*0%	*40%	100%
Workload (Night) – Very Intense/Excessive	34%	67%	*25%	100% (67/33)	*0%	*0%	75%	*0%
Workload (Weekends) – Very Intense/excessive	61%	100%	100%	83% (67/17)	67% (67/0)	*0%	60%	100%
Good support from senior trainees (when workload excessive) (Q.18)	80%	67%	*75%	*100%	*100%	No Data	67%	No Data
Good support from Consultant (Q.19)	74%	67%	*75%	*100%	67%	No Data	67%	50%
Attendance at Regional Teaching (Q.20) - 50% or more sessions	87%	*100%	*100%	*50%	*100%	*100%	*100%	*100%
Protected local teaching: At least 2 hrs/week (Q.24)	26%	0%	0%	0%	*100%	0%	40%	*50%
Protected local teaching: 1 hr/week	24%	33%	25%	0%	0%	50%	40%	0%
Protected local teaching: Less than 1 hr/week	50%	67%	75%	100%	*0%	50%	20%	50%
Local Teaching: Consultant attendance - Always/Usually (Q.28)	58%	33%	50%	33%	*100%	0%	80%	*100%
Critical Appraisal & Research – active culture/ encouraged to participate (posters/presentations/research) (Q.30)	28%	0%	25%	17%	33%	0%	20%	*50%
Able to set up QI/ Active culture of QI (Q.31) - (yes)	58%	33%	50%	33%	67%	0%	40%	50%
Educational Supervision - Satisfactory (Q.33) (Excellent/Above average)	91% (67%)	*100% (67%)	*100% (100%)	67% (17%)	*100% (0%)	50% (50%)	80% (80%)	*100% (100%)
Clinical Supervision (Day time) - Acceptable (Q.34) (Excellent/Above average)	94% (67%)	*100% (0%)	*100% (75%)	83% (67%)	*100% (67%)	*100% (0%)	*100% (80%*)	*100% (0%*)
Clinical Supervision (OOH) - Acceptable (Q.35) (Excellent/Above average)	94% (34%)	*100% (0%)	75% (50%)	*100% (50%)	*100% (33%)	*100% (0%)	*100% (40%)	*100% (0%*)
No difficulty getting WPBAs needed for progression (Q.36)	72%	*100%	50%	83%	*100%	50%	60%	*100%
Feedback:(Q.37) At least a few times a month	33%	0%	50%	33%	33%	0%	40%	50%
Feedback: Once a month or less	67%	100%	50%	67%	67%	100%	60%	50%
OVERALL Satisfaction: Placement rated as Excellent/Good	44%	33%	50%	33%	*100%	0%	50%	0%
OVERALL Satisfaction: Placement rated as Acceptable	27%	33%	25%	50%	0%	0%	25%	0%
OVERALL Satisfaction: Placement rated as Less than satisfactory/Poor	29%	33%	25%	17%	*0%	100%	25%	100%

APPENDIX 3: Targets and Colour coding for PQ Survey tables of **TRAINING OPPORTUNITIES**

GENERIC & CLINICAL CiPs

Targets and Colour coding for **ACCESS to Training Opportunities (TOs)**

ACCESS to TOs sufficient to meet training needs % of trainees			
≥50%	≥75%	≤50%	≤30%

Targets and Colour coding for **QUALITY of Training Opportunities**

QUALITY of TOs (Excellent/Good and occurring at most attendances) - % of trainees			
≥50%	≥75%	≤50%	≤30%

PRACTICAL PROCEDURES

Targets and Colour coding for **ACCESS to Training Opportunities (TOs) in PRACTICAL PROCEDURES**

ACCESS to TOs sufficient to meet training needs - % of trainees			
≥50%	≥75%	≤50%	≤30%

Targets and Colour coding for **QUALITY of Training Opportunities in PRACTICAL PROCEDURES**

QUALITY of TOs (Excellent/Good and occurring at most attendances) - % of trainees			
≥50%	≥75%	≤50%	≤30%

APPENDIX 4A: **GENERIC & CLINICAL CiPs - ACCESS TO Training Opportunities (TOs): TRUST DATA**

Training Opportunities (TRUSTS) (Sufficient TOs to meet training needs)	N.I 2021 Regional	TRUST A	TRUST B	TRUST C	TRUST D	TRUST E
Generic CiPs						
Functioning within NHS organisational and management systems	88%	95%	100%	100%	73%	71%
Able to deal with ethical & legal issues related to clinical practice	88%	86%	100%	100%	82%	86%
Communication & Decision making	94%	95%	100%	100%	91%	86%
Patient safety and QI in patient care	73%	82%	80%	71%	64%	57%
Research & Data Management	58%	73%	80%	29%	45%	43%
Acting as a Clinical Teacher and Clinical Supervisor	73%	73%	80%	100%	55%	71%
Clinical CiPs						
Managing an acute unselected take	70%	55%	80%	100%	82%	72%
Managing an acute specialty-related take	67%	59%	100%	72%	73%	57%
Providing continuity of care to medical in-patients	96%	96%	100%	100%	100%	86%
Managing outpatients with long term conditions	58%	68%	80%	58%	45%	29%
Managing medical problems in patients in other specialities and special cases	75%	78%	100%	71%	55%	85%
Managing an MDT including discharge planning	94%	91%	100%	100%	100%	91%
Delivering effective resuscitation & managing the deteriorating patient	88%	91%	100%	100%	73%	91%
Managing end of life and palliative care skills	92%	91%	100%	100%	91%	85%

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APPENDIX 4B: GENERIC & CLINICAL CiPs - ACCESS TO Training Opportunities (TOs): SITE DATA

ACCESS to Training Opportunities (SITES) (Sufficient TOs to meet training needs)	N.I 2021 Regional	SITE A	SITE B	SITE C	►SITE D	SITE E	SITE F
Generic CIPs							
Functioning within NHS organisational and management systems	88%	100%	83%	100%	100%	100%	100%
Able to deal with ethical & legal issues related to clinical practice	88%	87%	83%	100%	100%	100%	100%
Communication & Decision making	94%	87%	83%	100%	100%	100%	100%
Patient safety and QI in patient care	73%	100%	83%	83%	0%	67%	100%
Research & Data Management	58%	100%	67%	67%	0%	67%	100%
Acting as a Clinical Teacher and Clinical Supervisor	73%	87%	83%	50%	100%	67%	100%
Clinical CIPs							
Managing an acute unselected take	70%	87%	67%	50%	100%	67%	100%
Managing an acute specialty-related take	67%	87%	60%	33%	N/A	100%	100%
Providing continuity of care to medical in-patients	96%	100%	80%	100%	100%	100%	100%
Managing outpatients with long term conditions	58%	75%	60%	86%	N/A	67%	100%
Managing medical problems in patients in other specialities and special cases	75%	87%	80%	67%	100%	100%	100%
Managing an MDT including discharge planning	94%	100%	100%	86%	100%	100%	100%
Delivering effective resuscitation & managing the deteriorating patient	88%	100%	100%	71%	100%	100%	100%
Managing end of life and palliative care skills	92%	100%	100%	83%	100%	100%	100%

► 1 respondent from this site

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ACCESS to Training Opportunities (SITES) (Sufficient TOs to meet training needs)	N.I 2021 Regional	SITE G	SITE H	SITE I	SITE J	SITE K	SITE L	SITE M
Generic CIPs								
Functioning within NHS organisational and management systems	88%	100%	100%	67%	100%	50%	80%	50%
Able to deal with ethical & legal issues related to clinical practice	88%	100%	100%	83%	100%	50%	80%	100%
Communication & Decision making	94%	100%	100%	100%	100%	50%	80%	100%
Patient safety and QI in patient care	73%	67%	75%	83%	33%	50%	40%	100%
Research & Data Management	58%	33%	25%	50%	33%	50%	40%	50%
Acting as a Clinical Teacher and Clinical Supervisor	73%	100%	100%	67%	67%	0%	60%	100%
Clinical CIPs								
Managing an acute unselected take	70%	100%	100%	100%	100%	0%	60%	100%
Managing an acute specialty-related take	67%	100%	50%	100%	67%	0%	60%	50%
Providing continuity of care to medical in-patients	96%	100%	100%	100%	100%	100%	80%	100%
Managing outpatients with long term conditions	58%	33%	75%	50%	67%	0%	20%	50%
Managing medical problems in patients in other specialties and special cases	75%	67%	75%	50%	100%	0%	80%	100%
Managing an MDT including discharge planning	94%	100%	100%	100%	100%	100%	80%	100%
Delivering effective resuscitation & managing the deteriorating patient	88%	100%	100%	83%	100%	0%	80%	100%
Managing end of life and palliative care skills	92%	100%	100%	83%	100%	100%	80%	100%

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APPENDIX 4C: GENERIC & CLINICAL CiPs – QUALITY of Training Opportunities (TOs): SITE DATA

QUALITY of Training Opportunities (Excellent/Good at all or most attendances)	N.I 2021 Regional	SITE A	SITE B	SITE C	►SITE D	SITE E	SITE F
Generic CiPs							
Functioning within NHS organisational and management systems	48%	43%	50%	71%	100%	100%	50%
Able to deal with ethical & legal issues related to clinical practice	52%	43%	83%	57%	100%	67%	50%
Communication & Decision making	58%	43%	83%	71%	100%	67%	50%
Patient safety and QI in patient care	48%	29%	67%	71%	0%	67%	50%
Research & Data Management	35%	43%	33%	43%	No Data	67%	0%
Acting as a Clinical Teacher and Clinical Supervisor	42%	43%	50%	43%	100%	67%	50%
Clinical CiPs							
Managing an acute unselected take	56%	71%	83%	43%	100%	67%	50%
Managing an acute specialty-related take	62%	71%	100%	43%	0%	100%	50%
Providing continuity of care to medical in-patients	64%	71%	83%	57%	100%	67%	50%
Managing outpatients with long term conditions	48%	43%	33%	57%	0%	67%	50%
Managing medical problems in patients in other specialities and special cases	47%	57%	83%	29%	No Data	67%	50%
Managing an MDT including discharge planning	68%	57%	100%	86%	100%	67%	50%
Delivering effective resuscitation & managing the deteriorating patient	62%	71%	100%	57%	100%	67%	50%
Managing end of life and palliative care skills	68%	71%	100%	43%	100%	67%	50%

► 1 respondent from this site

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QUALITY of Training Opportunities (Excellent/Good at all or most attendances)	N.I 2021 Regional	SITE G	SITE H	SITE I	SITE J	SITE K	SITE L	SITE M
Generic CIPs								
Functioning within NHS organisational and management systems	48%	0%	25%	40%	67%	0%	40%	0%
Able to deal with ethical & legal issues related to clinical practice	52%	33%	25%	40%	100%	0%	40%	0%
Communication & Decision making	58%	33%	25%	60%	100%	0%	60%	0%
Patient safety and QI in patient care	48%	33%	25%	60%	67%	0%	40%	0%
Research & Data Management	35%	33%	0%	40%	67%	0%	20%	0%
Acting as a Clinical Teacher and Clinical Supervisor	42%	67%	25%	20%	67%	0%	20%	0%
Clinical CIPs								
Managing an acute unselected take	56%	33%	50%	80%	67%	0%	40%	0%
Managing an acute specialty-related take	62%	33%	50%	100%	33%	0%	40%	50%
Providing continuity of care to medical in-patients	64%	67%	50%	80%	67%	0%	40%	50%
Managing outpatients with long term conditions	48%	67%	50%	60%	67%	0%	40%	0%
Managing medical problems in patients in other specialities and special cases	47%	33%	25%	60%	67%	0%	20%	0%
Managing an MDT including discharge planning	68%	67%	25%	80%	67%	0%	60%	50%
Delivering effective resuscitation & managing the deteriorating patient	62%	67%	50%	60%	67%	0%	40%	50%
Managing end of life and palliative care skills	68%	67%	50%	80%	100%	0%	60%	50%

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APPENDIX 5A: PRACTICAL PROCEDURES – ACCESS TO Training Opportunities (TOs): TRUST DATA

Training Opportunities available for Practical Procedures (Sufficient TOs to meet training needs)	N.I 2021 Regional	TRUST A	TRUST B	TRUST C	TRUST D	TRUST E
Advanced CPR	60%	55%	80%	86%	45%	71%
Direct (DC) cardioversion	36%	18%	100%	14%	55%	43%
Temporary cardiac pacing using an external device	9%	0%	40%	0%	18%	14%
Central Venous Cannulation	25%	32%	20%	17%	18%	29%
Access to circulation for resuscitation (femoral vein or intraosseous)	30%	23%	40%	29%	36%	43%
Pleural aspiration for fluid (diagnostic)	13%	5%	0%	29%	27%	14%
Pleural aspiration (pneumothorax)	15%	5%	0%	14%	36%	29%
Intercostal drain for pneumothorax	11%	5%	0%	29%	18%	14%
NG tube	83%	73%	100%	100%	73%	100%
Ascitic tap	47%	27%	60%	100%	36%	71%
Abdominal Paracentesis	40%	27%	60%	71%	27%	57%
Lumbar puncture	47%	36%	20%	86%	55%	57%

APPENDIX 5B: PRACTICAL PROCEDURES – ACCESS to Training Opportunities (TOs): SITE DATA

PRACTICAL PROCEDURES (Sufficient TOs to meet training needs)	N.I 2021 Regional	SITE A	SITE B	SITE C	►SITE D (1 trainee)	SITE E	SITE F	
Advanced CPR	60%	75%	60%	33%	100%	100%	50%	
►Direct (DC) cardioversion	36%	25%	33%	33%	0%	100%	100%	
►Temporary cardiac pacing using an external device	9%	0%	0%	0%	0%	67%	0%	
►Central Venous Cannulation	25%	38%	50%	50%	N/A	33%	0%	
Access to circulation for resuscitation (femoral vein or intraosseous)	30%	25%	75%	0%	0%	67%	0%	
►Pleural aspiration for fluid (diagnostic)	13%	0%	0%	0%	100%	0%	0%	
►Pleural aspiration (pneumothorax)	15%	13%	0%	0%	0%	0%	0%	
►Intercostal drain for pneumothorax	11%	13%	0%	0%	0%	0%	0%	
NG tube	83%	100%	100%	25%	100%	100%	100%	
►Ascitic tap	47%	25%	80%	0%	0%	67%	50%	
►Abdominal Paracentesis	40%	38%	75%	0%	0%	67%	50%	
Lumbar puncture	47%	50%	60%	33%	0%	0%	50%	
PRACTICAL PROCEDURES (Sufficient TOs to meet training needs)	N.I 2021 Regional	SITE G	SITE H	SITE I	SITE J	SITE K	SITE L	SITE M
Advanced CPR	60%	100%	75%	67%	33%	0%	60%	100%
►Direct (DC) cardioversion	36%	0%	25%	67%	67%	0%	20%	100%
►Temporary cardiac pacing using an external device	9%	0%	0%	33%	0%	0%	0%	50%
►Central Venous Cannulation	25%	50%	0%	33%	0%	0%	40%	0%
Access to circulation for resuscitation (femoral vein or intraosseous)	30%	67%	0%	50%	33%	0%	40%	50%
►Pleural aspiration for fluid (diagnostic)	13%	33%	25%	50%	0%	0%	20%	0%
►Pleural aspiration (pneumothorax)	15%	33%	0%	50%	33%	0%	20%	50%
►Intercostal drain for pneumothorax	11%	67%	0%	33%	0%	0%	20%	0%
NG tube	83%	100%	100%	67%	100%	0%	100%	100%
►Ascitic tap	47%	100%	100%	50%	33%	0%	60%	100%
►Abdominal Paracentesis	40%	100%	50%	50%	0%	0%	40%	100%
Lumbar puncture	47%	100%	75%	83%	33%	0%	40%	100%

APPENDIX 5C: PRACTICAL PROCEDURES – QUALITY of Training Opportunities (TOs): TRUST DATA

Training Opportunities available for Practical Procedures (Excellent/Good at all or most attendances)	N.I 2021 Regional	TRUST A	TRUST B	TRUST C	TRUST D	TRUST E
Advanced CPR	41%	45%	20%	43%	45%	40%
▶Direct (DC) cardioversion	29%	27%	60%	14%	27%	40%
▶Temporary cardiac pacing using an external device	14%	14%	20%	0%	18%	20%
Central Venous Cannulation	No Data Available					
▶Access to circulation for resuscitation (femoral vein or intraosseous)	16%	23%	20%	0%	10%	20%
▶Pleural aspiration for fluid (diagnostic)	18%	18%	0%	14%	20%	40%
▶Pleural aspiration (pneumothorax)	18%	18%	0%	14%	20%	40%
▶Intercostal drain for pneumothorax	18%	18%	0%	14%	20%	40%
NG tube	50%	59%	50%	57%	33%	40%
▶Ascitic tap	37%	36%	20%	43%	44%	40%
▶Abdominal Paracentesis	26%	27%	20%	29%	33%	20%
Lumbar puncture	41%	41%	0%	57%	50%	40%

▶ Not all practical procedures are available on each site and in each placement

APPENDIX 5D: PRACTICAL PROCEDURES – QUALITY of Training Opportunities (TOs) in PRACTICAL PROCEDURES: SITE DATA

PRACTICAL PROCEDURES (Excellent/Good at all or most attendances)	N.I 2021 Regional	SITE A	SITE B	SITE C	►SITE D (1 trainee)	SITE E	SITE F	
Advanced CPR	41%	38%	50%	57%	0%	33%	0%	
►Direct (DC) cardioversion	29%	50%	33%	0%	0%	67%	50%	
►Temporary cardiac pacing using an external device	14%	25%	17%	0%	0%	33%	0%	
►Central Venous Cannulation	No Data Available							
Access to circulation for resuscitation (femoral vein or intraosseous)	16%	25%	50%	0%	0%	33%	0%	
►Pleural aspiration for fluid (diagnostic)	18%	25%	33%	0%	0%	0%	0%	
►Pleural aspiration (pneumothorax)	18%	25%	33%	0%	0%	0%	0%	
►Intercostal drain for pneumothorax	18%	25%	33%	0%	0%	0%	0%	
NG tube	50%	63%	100%	14%	100%	50%	50%	
►Ascitic tap	37%	63%	50%	0%	0%	33%	0%	
►Abdominal Paracentesis	26%	50%	33%	0%	0%	33%	0%	
Lumbar puncture	41%	63%	50%	14%	0%	0%	0%	
PRACTICAL PROCEDURES (Excellent/Good at all or most attendances)	N.I 2021 Regional	SITE G	SITE H	SITE I	SITE J	SITE K	SITE L	SITE M
Advanced CPR	41%	33%	50%	67%	33%	0%	50%	0%
►Direct (DC) cardioversion	29%	0%	25%	33%	33%	0%	50%	0%
►Temporary cardiac pacing using an external device	14%	0%	0%	17%	33%	0%	25%	0%
►Central Venous Cannulation	No Data Available							
Access to circulation for resuscitation (femoral vein or intraosseous)	16%	0%	0%	17%	0%	0%	25%	0%
►Pleural aspiration for fluid (diagnostic)	18%	33%	0%	33%	0%	0%	50%	0%
►Pleural aspiration (pneumothorax)	18%	33%	0%	33%	0%	0%	50%	0%
►Intercostal drain for pneumothorax	18%	33%	0%	33%	0%	0%	50%	0%
NG tube	50%	67%	50%	40%	50%	0%	50%	0%
►Ascitic tap	37%	67%	25%	60%	50%	0%	50%	0%
►Abdominal Paracentesis	26%	67%	0%	60%	0%	0%	25%	0%
Lumbar puncture	41%	67%	50%	67%	50%	0%	50%	0%