NIMDTA
Deanery Visit to Southern Trust
FINAL REPORT

Hospital Visited	**Craigavon Area Hospital, Southern Trust**		
Specialty Visited	**General Medicine**		
Type of Visit	**Cyclical visit**		
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr Ahmed Khan, Interim Medical Director Mr Colin Weir, AMD Education & Training		
Date of Visit	**3rd May 2018**		
Visiting Team	Dr Richard Tubman, Associate Dean (Chair) Dr Janet Harding, Deputy Head of School, Medicine Dr Harish Shetty, External Representative Dr Aine McShane, GP Representative Mr Rob Lynas, Lay Representative Mrs Gillian Carlisle, Quality & Revalidation Manager, NIMDTA		
Rating Outcome	**Red**	**Amber**	**Green**
	7	3	6

Purpose of Deanery visits	The General Medical Council (GMC) requires UK Deaneries/LETBs to demonstrate compliance with the standards and requirements that it sets (GMC-Promoting Excellence 2016). This activity is called Quality Management and Deaneries need to ensure that Local Education and Training Providers (Hospital Trusts and General Practices) meet GMC standards through robust reporting and monitoring. One of the ways the Northern Ireland Deanery (NIMDTA) carries out its duties is through visiting Local Education and Training Providers (LEPS). NIMDTA is responsible for the educational governance of all GMC-approved foundation and specialty (including General Practice) training programmes in Northern Ireland.
Purpose of this visit	This is a cyclical visit to assess the training environment and the postgraduate education and training of trainees in General Medicine training at Craigavon Area Hospital.
Circumstances of this visit	The Deanery Visiting Team met with educational leads, trainees and trainers in General Medicine at Craigavon Area Hospital.
Relevant previous visits	Cyclical visit to General Medicine, Craigavon Area Hospital, 22nd November 2012
Pre-visit meeting	27th April 2018
Purpose of pre-visit meeting	To review and triangulate information about postgraduate medical education and training in the unit to be visited.
Pre-Visit Documentation Review	Previous visit report 22nd November 2012 and subsequent Trust Action Plan Trust Background Information Template 6th April 2018 Pre-visit SurveyMonkey® May 2018 GMC National Training Surveys 2017
Types of Visit	Cyclical Planned visitation of all Units within 5 years Re-Visit Assess progress of LEP against a previous action plan Decision at Quality Management Group after grading of cyclical visit Reconfiguration of Service Problem-Solving Visit Request of GMC Request of RQIA Quality Management Group after review of submitted evidence sufficient to justify investigation and not suitable for investigation at Trust or Specialty School level.

This report reflects the findings from the trainees and trainers who were available to meet with the visiting team on the day of the visit and information arising from the pre-visit survey.
Please note the following recommendations from the Francis Report on Mid-Staffordshire NHS Foundation Trust Public Inquiry on Training and Training Establishments as a Source of Safety Information:

- **<u>Recommendation 160</u>: Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.**
- **<u>Recommendation 161</u>: Training visits should make an important contribution to the protection of patients. Obtaining information directly from trainees should remain a valuable source of information.**

Educational Leads Interviewed

Mr Colin Weir, AMD Education & Training
Dr Lynn Wilson, Foundation Program Director
Mr Simon Gibson, Assistant Director, Medical Directorate

Trainees Interviewed

	F1	F2	CT1/2, GPST, ST1-2	ST3+
Posts	10	6	8 CT1/2, 3 GPST, 1 ST1 (ACCS)	12
Interviewed	6	3	3GPST1, 1 ST1 (ACCS), 4 CT1/2	6 + 1 LAT3

Trainers Interviewed

5

Feedback provided to Trust Team

Mr Shane Devlin, Chief Executive
Dr Ahmed Khan, Interim Medical Director
Mr Colin Weir, AMD Education & Training
Dr Lynn Wilson, Foundation Program Director
Mr Simon Gibson, Assistant Director, Medical Directorate
Ms Anne McVeigh, Assistant Director, Acute services
Ms Kelly Wylie, Education and Training Department

Contacts to whom the visit report is to be sent to for factual accuracy check

Dr Ahmed Khan, Interim Medical Director
Mr Colin Weir, AMD Education & Training
Dr Lynn Wilson, Foundation Program Director

Background

Organisation:
Craigavon Area Hospital (CAH) is a busy district general hospital. There are medical subspecialties in Acute Medicine, Diabetes and Endocrinology, Respiratory Medicine, Cardiology, Care of the Elderly, Gastroenterology and Rheumatology.

Staff:
There are 11 consultants and 4 locum consultants across the range of sub-specialties. There are 10 Associate Specialists and 7 Specialty Doctors. There are 12 ST3+, 1 ST1 (ACCS), 8 CT1/2, 3 GPST, 6 F2 and 10 F1 posts in Medicine.
There have been some recent difficulties in recruiting substantive consultants into vacant posts.

Other Sites: There are care of the elderly/rehab patients in Lurgan Hospital and South Tyrone Hospital.

NTS: 2017
There was a green indicator for study leave for CMTs. There were red indicators for: overall satisfaction, reporting systems, teamwork, supportive environment and educational governance for F1; workload for F2 and for clinical supervision out of hours, workload and supportive environment for GPST. There has been a red indicator for overall satisfaction for F1 in three successive years.
There was a 55% response to the trainer survey.

Pre-visit SurveyMonkey:
There were 21/40 responses to the May 2018 SurveyMonkey.

Previous Visits/Concerns:
The 2012 visit was graded as B2: satisfactory (with conditions).

Findings against GMC's Standards for Medical Education and Training (Promoting Excellence, 2016)

Theme 1: Learning Environment and Culture

S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
S1.2: The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Induction (R1.10, 1.13, 1.19)
Trust Induction
All trainees said that the Trust induction was comprehensive. There was a specific induction to general medicine on the second day for all medical staff. However some of the STs were rostered to go to clinics when this induction was happening. Badges and passwords were given out promptly.
Unit Induction
F1: F1 trainees said that they were not clear about what wards they were going to be allocated to in August.
F2: F2 trainees also said that their ward induction was quite brief and informal.
GPST/CT/ST: CT trainees said that ward induction was generally quite good in CAH, although GPST/CT trainees did not receive an induction to Lurgan Hospital.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
F1/F2: F1 and F2 trainees said that they were supervised well by the CTs and SpRs.
GPST/CT/ST: Trainees said that supervision by senior staff was good in AMU and respiratory. The consultant of the week was always around during the day. Trainees said that in their view at times there could be a lack of hands-on decision making by some of the locum consultants in AMU.
ST3+ trainees reported that sometimes they might have to do cardiology clinics on-site or off-site when there was no consultant available.

Handover (R1.14)
F1 trainees said that they do not attend a morning handover; instead they handed over directly to their peers in the morning at the end of the night shift before finishing at 9.30am.
There is no formally organised handover in medicine in the mornings. There is a post-take ward round in AMU at 8.00am, attended by F2 trainees and above. Handover at this was described as "quite poor" by trainees; there was no detailed discussion of patients or triage, just a "tick list" which was not seen as very helpful. There were no records kept. Trainees reported that in their view there was a "lack of responsibility" by some consultants, and "locum consultants were not interested".
There is a post-take round of outlier patients by the outlier team; these patients were identified by searching Patient Centre for admissions. Trainees said that also they would look through the notes in the ward trolley to identify new patients. Trainees said that there didn't seem to be a formal system for tracking patients. Outliers were notified to them by the ward nurses.
There is a Hospital At Night (H@N) handover at 8.30pm which is attended by everyone except the consultant. Trainees said that this could be made better by including the number of outliers, the number of free ICU spaces, etc.

Practical Experience (R1.19)

F1: F1 trainees said that they were ward-based but moved between wards frequently as there was currently no F1 "floater". They did a variety of ward tasks that were written in a ward jobs book or sometimes given directly to them by nurses. Sometimes nurses would write the tasks into the book even though the F1 trainee was standing beside them. They did on average six discharge letters per day, but received no feedback on their quality. CT trainees reported that in their view "F1 were hounded to do discharge letters as soon as they come onto the ward". They took blood though nurses also did this at times. They were able to get on some ward rounds particularly in cardiology. They clerked in some patients out of hours and could present them to the SpRs. They were able to do some practical procedures if they asked.

F1s said that they appreciated the support they received from the ward pharmacists.

F2: F2 trainees went on consultant ward rounds or did their own ward reviews. They did ward duties and some procedures. They did not review outliers and did not attend clinics.

GPST/CT: Trainees in AMU do a post-take ward round from 8.00-11.00am, followed by ward duties. In the other medical wards trainees go on consultant ward rounds or carry out their own rounds. Trainees are able to do some procedures in AMU (such as LPs) but in respiratory medicine there were limited opportunities for procedures as locum staff tended to do these.

CT trainees said that they were encouraged to go to clinics but were not rostered to do so, and it was usually too busy in the wards anyway. Only three of the eight GPST/CT trainees that we spoke with had been to any clinics.

<u>Lurgan Hospital</u>

Trainees are assigned to the two wards in Lurgan hospital for three months at a time; one ward is for more medically unstable patients whereas the other is mostly rehab. The workload was described as "bloods and letters", although rehab was said to be good and there had been some exposure to the acute care at home service. They did not do any procedures whilst in Lurgan so had to try to catch up in the remainder of their time in CAH. Trainees said that they found this very frustrating.

There were often admissions to Lurgan between 5.00-10.00pm. Trainees said that they would often have to clerk in some of these after their shift had finished (and they were back to work in CAH the next morning). Trainees said that the patients' notes and Kardexes did not always come over with them from CAH, which delayed things.

<u>South Tyrone Hospital</u>

One of the GPST/CT trainees is posted to South Tyrone Hospital for three months at a time. We did not hear from any trainees who were on that rotation, so cannot directly comment on its usefulness for training at this level.

ST: ST trainees said that they rarely had to do ward work. They did ward rounds, saw referrals and attended clinics.

CoE: There is a daily MDM in the care of the elderly ward and two to three clinics/week. The CoE ST3+ trainee was moved into the acute care at home service which they valued. They said that as a result that they "were no longer being hounded by the bed manager" in Lurgan Hospital.

Diabetes/endocrine: there are adequate diabetes clinics but not enough endocrine clinics because these are cancelled when the endocrine consultant is consultant of the week.

Rheumatology: there has been a reduction in available clinics since one consultant left CAH; the remaining clinics are off site and attended by a specialty doctor.

Cardiology: there is one clinic per month but compensated for by lots of practical opportunities in the cath lab, CCU and for ECHO.

Workload (R1.7, 1.12)

F1/F2: Daytime workload was said to be busy but manageable. It was very busy out of hours and particularly at weekends. There was an extra F1 locum to help at weekends. F1 trainees said that in their opinion there had been an imbalance in the number of F1 between medicine and surgery over the winter months, with proportionally too few F1s in medicine.

GPST/CT: Workload by day could be busy in certain areas such as respiratory, or in Lurgan Hospital after 5.00pm. Out of hours workload was busy and weekends were said to be very busy and disorganised.

ST: Workload was reported to be very busy especially at weekends, when it was excessive during the winter. This was compounded by rota gaps and an inefficient patient tracking system.

EWTR Compliance (R1.12e)

F1: Band 2a

F2: Band 1a.

Other trainees thought that their rotas were compliant. Most got away promptly at the end of shifts, although there was often a run-over in the evenings in Lurgan Hospital.

Hospital and Regional Specialty Educational Meetings (R1.16)
There is Foundation teaching on Wednesdays. This started in January of this year and was viewed positively by F1 and F2 trainees, although they did not present cases themselves. There is general teaching on Thursdays for all staff, and consultants attend. This teaching had been cancelled frequently of late.
Trainees said they were sometimes bleeped out of teaching but usually for important things.
There is weekly teaching in several specialties including CoE, respiratory, echo, rheumatology and in Lurgan Hospital.
F2 trainees were able to get to Generic Skills teaching at NIMDTA. GPST trainees found it difficult to get to their teaching sessions.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)
There is good access to UpToDate and a good WiFi service. There were no regular simulation activities apart from ALS at the start of the post.

Quality Improvement and Audit (R1.3, 1.5, 1.22)
Trainees reported that they could do audit or QI if they actively sought it out but they were often too busy to complete these.

Patient Care (R1.1, 1.3, 1.4)
Trainees said that in their view the quality of patient care was good or very good, but that staff were always far too busy.

Patient Safety (R1.1-1.5)
There were no specific patient safety issues reported.
Trainees said that they were concerned about the lack of continuity of care for patients admitted over the weekend or at bank holidays.
They reported that outliers were seen only once per day and seemed to be of lesser priority. They said that these patients were sometimes in wards where the nurses were not comfortable looking after their particular medical conditions. It was sometimes not clear who was responsible for the outlier team, or who to contact.
F1/F2 trainees said that they were not sure how to use the Datix system, although CTs had been shown how to use it.

Theme 2: Educational Governance and Leadership
S2.1: The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met.
S2.2: The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety.
S2.3: The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Educational Supervision (R2.11, 2.14, 2.15)
All trainees have a named educational supervisor and are able to meet regularly with them. There are no issues with getting WBAs completed, although there were not many opportunities for WBAs in Lurgan Hospital.
Trainees reported that it was difficult to do ACATs in AMU as the locum consultants there were unwilling to do them with trainees.
We noted from the Trust background information template that the Specialty Education Lead was the assigned educational supervisor for 7 CMTs.

Theme 3: Supporting Learners
S3.1: Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.

Feedback on Performance, Development and Progress (R3.13)
Trainees reported that they received informal feedback at times, such as at clinics, and in a limited manner on the post-take ward round.

Trainee Safety and Support (R3.2)
Trainees reported that they had been offered MAPA training to cope with patients who might become violent or aggressive.

Trainees were concerned about the effects of fatigue on their ability to drive home safely the next morning. There are facilities in the Halls to use if they are tired after a shift but these must be booked in advance.
There is a foundation trainee forum that meets every six weeks or so.

Undermining (R3.3)
X

Study Leave (R3.12)
Trainees said that the cardiology department had been supportive of their study leave as there was a separate cardiology sub-rota.

Theme 4: Supporting Educators
S4.1: Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.
S4.2: Educators receive the support, resources and time to meet their education and training responsibilities.

Trainer Support (R4.1-4.6)
Trainers said that their training role was incorporated into their job plans. They were educationally appraised annually.
They had been supported by the Trust to complete the requirements for trainer recognition.
Trainers said that there was not enough physical space for trainees in clinic and acknowledged that it was difficult for CT/GPST trainees to get to clinics because of pressures of work.

Theme 5: Developing and Implementing Curricula and Assessments
S5.2: Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

No issues identified.

Summary of Conclusions

The below conclusions have been categorised as follows:

i) Educational governance (training)

ii) Clinical governance or patient safety issues

Comment (if applicable)
The visit team noted that there was a relatively small number of substantive consultants in post, and that there have been difficulties recruiting at this level. The reliance on locums has had a knock-on effect on some aspects of training and supervision.

Areas Working Well
1. Trust induction is well-organised. Badges and passwords are given out in a timely manner.
2. Educational supervision is good.
3. There is good support for F1 trainees by the ward pharmacists.
4. There is a regular Foundation forum.
5. A number of sub specialties run weekly teaching for staff.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. Trainees reported that they had been offered MAPA training to cope with patients who might become violent or aggressive.

Areas for Improvement (issues identified has a limited impact on a trainee's education and training, or the quality provision for the patient):

	Educational Governance	Clinical Governance	RAG
1. Induction. F1 should be clearly informed what wards they are going to be allocated to in August.	✓	✓	Green
2. Practical Experience. The use of ward books to communicate with F1s should be discouraged. Face-to-face discussion of tasks would improve team working and education of F1s.	✓	✓	Red
3. Induction. ST3+ should be able to attend the general medical induction on the second day of induction, and not expected to cover clinics then.		✓	Green
4. Induction. There is variability in unit induction. All trainees should have some form of induction to the clinical area or ward that they will be working in. Ideally this should involve meeting relevant staff and a walk-round of the department.	✓	✓	Amber
5. Workload. Trainees reported that in their view there was an imbalance in the numbers of F1 in medicine and surgery during the winter: proportionally more were needed in medicine.	✓	✓	Green
6. Hospital and Regional Specialty Educational Meetings. Thursday teaching sessions have been cancelled frequently. We would encourage a review of the content and relevance of the local teaching programme.	✓		Green

Areas of Concern (trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement and/or patients within the training environment are receiving safe care but the quality of their care is recognised as requiring improvement):

	Educational Governance	Clinical Governance	RAG
1. Induction. Trainees allocated to Lurgan Hospital must be given a suitable induction.	✓	✓	Amber
2. Clinical Supervision. Trainees said that in their view at times there could be a lack of hands-on decision making by some of the locum consultants in AMU.	✓	✓	Green
3. Handover. The identification and tracking of outlier patients is very inefficient. At times it is not clear who is responsible for the outlier patient post take team.	✓	✓	N/A

4. Handover. There is no formal morning handover in General Medicine. There are post take ward rounds but these are not an effective system of handover. Handover does not appear to be adequately supported by locum consultants. There are no formal records retained.	✓	✓	Red
5. Practical Experience. GPST trainees do not attend any clinics. This is a missed opportunity for an important aspect of their training.	✓		Red
6. Practical Experience. Whilst there are some opportunities for experience in rehab in Lurgan Hospital, a three-months rotation to Lurgan does not provide a great deal of educational value. Much of the work is of a service nature and is often concerned with admissions of patients transferred from CAH between 5.00-10.00pm.	✓	✓	Red
7. Patient Safety. Trainees said that they were concerned about the lack of continuity of care for patients admitted over the weekend or at bank holidays.	✓	✓	N/A
8. Educational Supervision. Trainees reported that it was difficult to do ACATs in AMU as the locum consultants there were unwilling to do them with trainees.	✓		Green
9. EWTR Compliance. Trainees' evening shift in Lurgan Hospital often runs on beyond 10.00pm, and sometimes by several hours.	✓	✓	Amber

Areas of Significant Concern (patients/trainees within the training environment are at risk of coming to harm and/or trainees are unable to achieve required outcomes due to poor quality of the training posts/programme):

	Educational Governance	Clinical Governance	RAG
1. Practical Experience. Core medical trainees rarely attend outpatient clinics. There is a curriculum requirement for CTs to attend clinics; therefore this must be addressed as a matter of priority. Clinic attendance might be improved by formally rostering CTs to a clinic week or similar arrangement, and by improving the physical clinic space.	✓	✓	Red
2. Undermining. X	✓	✓	Red
3. Clinical Supervision. ST3+ reported that sometimes they might have to do cardiology clinics on-site or off-site when there was no consultant available.	✓	✓	Red

Summary Rating Outcomes		
Red	**Amber**	**Green**
7	3	6