NIMDTA
Deanery Enhanced Monitoring Review of Cardiothoracic Surgery,
Royal Victoria Hospital, Belfast Trust

FINAL REPORT

Hospital Visited	**Royal Victoria Hospital Belfast**
Specialty Visited	**Cardiothoracic Surgery Unit**
Type of Visit	**Enhanced Monitoring Visit**
Trust Officers with Postgraduate Medical Education & Training Responsibility	**Dr X, Medical Director** **Dr X, Deputy Medical Director** **Dr X, Director of Medical Education** **Dr X, Deputy Director of Medical Education** **Mr X, Clinical Director for Cardiothoracic Surgery**
Date of Visit	**26 November 2021**
Visiting Team	**Dr X, Director Hospital Specialty and Professional Development, NIMDTA [Chair]** **Mr X, SAC Liaison Member** **Dr X, Director Foundation Training, NIMDTA** **Mr X, Lay Representative** **Mr X, GMC Representative** **Mrs X, Quality & Revalidation Manager, NIMDTA**

Rating Outcome	**Red**	**Amber**	**Green**	**White[1]**
	7	4	0	0

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 an Enhanced Monitoring visit to assess the training environment and the postgraduate education and training of trainees in Cardiothoracic training at Belfast Health and Social Care Trust. The GMC placed training in cardiothoracic surgery in BHSCT into their Enhanced Monitoring process in February 2021 as they remain concerned that training is not meeting requirements relating to the following standards in Promoting Excellence: R1.1: Organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences R3.3: Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.
Circumstances of this visit	The Deanery Visiting Team met with trainees in the Cardiothoracic unit at Belfast Health and Social Care Trust and all current programme trainees. The visit was an initial on-site visit and a separate Zoom meeting accommodated two trainees who were unable to attend on the day.
Relevant previous visits	Cyclical visit 20 June 2019
Pre-visit meeting	16 November 2021
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 reports 20 June 2019 and subsequent Trust Action Plan Trust Background Information Template November 2021 Pre-visit Survey Monkey November 2021 GMC National Training Survey up to 2021
Types of Visit	Cyclical Planned visitation of all Units within 5 years Re-Visit Assess progress of LEP against a previous action plan

[1] Risks identified during the visit which were closed through action planning by the time of the final report.

	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:

- Recommendation 160: 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.
- Recommendation 161: 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

	F1	F2	CT/ST1-2	ST3+
Posts	2	3	4	3
Interviewed	1	1	4	3* *2 of 3 post visit meeting

Trainers Interviewed

Trainers were not interviewed

Feedback provided to Trust Team

Dr X, Deputy Medical Director
Dr X, Director of Medical Education
Dr X, Deputy Director of Medical Education
Mr X, Specialty Tutor for Surgery (Retired Consultant Surgeon)
Mr X, Consultant Cardiothoracic Surgeon & Training Programme Director
Mr X, Consultant Thoracic Surgeon
Mr X, Consultant Cardiothoracic Surgeon & Training Programme Director and Clinical lead for Cardiac surgery,

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

Dr X, Medical Director
Dr X, Director of Medical Education
Dr X, Deputy Director of Medical Education

Background

Organisation: Cardiothoracic surgery training is provided on the RVH site.

Staff: There are 10 consultants. There are 3 SASG doctor; 1 ST2, 2ST3+, 1 ST3+ on OOP, 3 CTs, 2 F2 and 3 F1 posts in Cardiothoracic surgery. 4 Surgical Care Practitioners

NTS 2021: Post Specialty (all grades): 1 Red Outlier (Facilities), 3 Pink Outliers (overall Satisfaction, Adequate Experience and Curriculum Coverage).
Programme Group (ST3+): 3 Pink Outliers (Clinical Supervision, Teamwork and Educational Governance)

Pre-visit Survey: 7 respondents

Previous Visits/Concerns: 20 June 2019

Practical Experience:

1. F2 trainees raised issues in relation to access to procedures which are currently being performed by SNPs.
2. There are issues with practical experience in cardiac theatres for CT trainees, who report that they do not often get to perform procedures which are curriculum requirements as these are being carried out by SNPs.
3. There is a lack of consultant presence at the early stages of the surgery to which the core trainees should be gaining exposure

Undermining:

[redacted]

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)

There appears to be comprehensive Unit induction, this is face-to-face and led by two consultants. The unit induction covers both Cardiac and Thoracic Surgery.

An ST trainee describes that they are undertaking a QIP to update the current induction handbook.

Trust virtual induction also appears to be satisfactory for those who attended, however, a number of the Core trainees did not attend and they have not previously worked in the BHSCT. All trainees reported that they had access to computer system passwords and possessed ID badges.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)

Foundation and Core level trainees report a good level of supervision and that a significant proportion of their day to day ward and OOH supervision is provided by middle grade tier (combination of ST3+ and Clinical Fellows). Training in the unit is predominantly led by the ST3+/ middle tier grade, although there is always consultant supervision available.

Supervision in outpatients is described as excellent and there is opportunity to discuss patients with consultants and middle tier doctors.

There is a reported lack of consultant presence at the early stages of surgery; however, middle tier doctors/ ST3+ are present.

Some consultants are described by trainees as being unapproachable when contacted by telephone to discuss patient related issues. These interactions are described as difficult and although it relates to the minority of consultants it makes the trainees hesitant to call these individuals. Generally, the core level trainees would approach registrars in the first instance.

[redacted]

ST3+: Supervision in outpatients is described as excellent and there is opportunity to discuss patients. Consultants discuss and see all new patients.

While ST3+ trainees do not feel they are working beyond their competency level, on direct questioning is was reported that there is not always a consultant in theatre. Starting theatre lists and participating in the WHO checklist is not common practice for all consultants.

Handover (R1.14)

There is no single handover system.

Foundation / Core trainees verbally communicate with their peers if there is felt to be a patient issue that needs to be relayed and then join the ST3+ led ward round. At 6pm the on call StR gets a verbal handover by telephone from the Cardiac StR, Thoracic StR and the theatre-based StR.

In the morning StRs are in various sites within the RVH. The on-call StR maybe at home and communicates through WhatsApp but does not include any patient identifiable details; patient details are sent to a Trust email. There is no face-to-face meeting for handover or consultant involvement.

The Thoracic team have a virtual 'board' round and a number of Thoracic consultants attend this, the ST3+ trainee assigned to the ward then undertakes the face-to-face ward round. The Thoracic consultants may return separately at a later time point to assess their own patients and if the management plan implemented by the ST3+ alters, this is generally communicated to the Foundation and Core trainees by the ST3+.

There is no Cardiac consultant described as being present at the morning virtual or the face-to-face ward round, the ST3+ leads this ward round and consultants see their own patients on an ad-hoc basis either daily or on alternate days towards the end of the working day.

The core doctors do not report using or having access to a handover sheet. The ST3+ reference a computer based list that is updated regularly and includes the active list of patients and management plans/investigations. This can be viewed within the Trust or for those with remote access. Core trainees were interviewed earlier in the course of the visit and did not communicate

any knowledge or use of this system, although this is at odds with some ST3+ trainees who describe it is used by all levels of trainees. Nurses have a separate handover and documents.
Out of Hours transfers are common and well communicated.

Practical Experience (R1.19)
Ward duties – Foundation and Core
F1 doctors do not cover the cardiac patients. F1 doctors cover vascular and thoracic units. Core trainees and F2 cover both cardiac and thoracic patients.
Core trainees when attached to the Thoracic unit describe a 60:40 split between service and training.
For the Core level trainees the balance of service to training for Cardiac cover was described as 98:2 and duties involved discharge summaries, phlebotomy and cannula insertion. There is no F1 cover for the cardiac unit.
Nurses at night did take some bloods; however, this was estimated as being for 50% of patients. There is no reliable system in place to know which patients still needed bloods the following morning. The current system involves leaving blood labels/forms the evening before on the patient's bed and the following morning checking with each patient if bloods were done. Later in the day when checking results it becomes apparent that bloods may not have been performed. Trainees reported a lot of missed bloods. There is no Phlebotomist or Physician Associate presence in the Cardiothoracic unit.
Providing care to ward patients is complicated by the varying practice among consultants and this lack of consistency is difficult for trainees, an example offered was the replacement of potassium or magnesium. The impact of this is that trainees need to modify treatment regimes in the same clinical scenario depending on who the named consultant is and if they do not then the repercussion is that consultants, 'registrars' and nursing staff will openly correct them and that the feedback is very direct. This knowledge of individual practice is passed down verbally by other team members or will be communicated openly on the ward if they get this 'wrong'. The level of responsibility afforded to core trainees at times is considered to be treating them like medical students.

ST3+
ST3+ is either Cardiac or Thoracic based by day but during OOH cover both Cardiac and Thoracic.
Training and experience at ST3+ level appears to be very good with adequate exposure and access to theatre.
They also get good access to outpatient clinics with a mixture of new and review patients.
ST3+ trainees described positive interactions with surgical care practitioners (SCPs). Programme trainees who have been trained did not retain the skill to undertake endoscopic vein harvesting independently.

Theatre
Core level trainees raised issues in relation to practical experience in cardiac theatres. In cardiac surgery only one surgeon takes open vein for coronary artery bypass grafting which limits the opportunities for training. Endoscopic vein is harvested by surgical care practitioners (SCPs) and it is described that the majority are reluctant to teach and train them in this procedure.
Core trainees felt that they were not given the opportunity to learn and found the interactions with some SCPs was perceived as not being supportive and have been told directly by some that they are not trainers.
The procedures that the F2/Core trainees are advised that they are expected to achieve (i.e. Vein Harvest, sternotomy) are being performed by SCPs. Trainees reported that they often view the same procedure multiple times with no active role and have limited learning opportunities. These issues have already been highlighted to the AES, and while there has been some acknowledgement of these concerns, the issue remains unresolved. Trainees further reported that there is a lack of consultant presence at the early stages of the surgery to which the core trainees should be gaining exposure.
Experience in sternotomy is very limited with only 1-2 performed per trainee over a 4 month period, despite the fact that there are reported to be approximately 10-12 sternotomies performed every week.
Single F2 doctor interviewed described availing of training opportunities and has attended clinics and theatre sessions.

Workload (R1.7, 1.12)
F1/F2/ Core Trainees reported that the day time work intensity was busy but manageable and that they are still able to get appropriate breaks. Trainees described weekends and nights as manageable.
ST3+ trainees described workload intensity as variable but manageable.

EWTR Compliance (R1.12e)
F2/CT1-2 trainees are on a EWTR compliant rota, although they did report staying 30 minutes late. Trainees stated that they did not feel coerced into staying late or covering gaps on the rota.
ST3+ report that they are on a Band 2A rota. There are staff shortages and therefore while this is released as a 1:8 rota, there are two gaps that need to be filled by locum slots. ST3+ works a 24 hour shift.

On a Sunday evening the StRs when not rostered to work are expected to assess the patients that they will operate on the following day.

Hospital and Regional Specialty Educational Meetings (R1.16)
F1 attend Trust teaching.
F2/CT1-2 Trainees reported that they have access to good formal teaching sessions which cover both Cardiac and Thoracic. Trainees get protected time to attend these sessions. Low fidelity simulation teaching has also been taking place, at which there is always consultant presence.
ST3+ Teaching is organised by the Training Programme Director and is split between Cardiac and Thoracic. Exam topics are covered during these teaching sessions. ST3+ trainees also reported that they get access to relevant courses throughout the year. The departmental teachings take place on Monday, Wednesday (journal club) and Friday and consultants are present in all these meetings. Regional teaching happens once a month. The trainees rated departmental teaching as good relative to other departments.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)
There were no concerns identified.
The newly appointed Clinical Director secured a computer for the StR on call room that removed the requirement to leave the room to access Trust systems on the ward when called during the night.

Quality Improvement and Audit (R1.3, 1.5, 1.22)
All trainees reported that they get plenty of opportunities for audits and QI projects. One trainee stated that he has undertaken an audit that has led to practice change in the department.

Patient Care (R1.1, 1.3, 1.4)
Patient care overall is good. However the trainees raised concerns that there are nursing shortages in the unit.

Patient Safety (R1.1-1.5)
There were no concerns raised. Some ST3+ trainees were aware of Datix; however, other trainees had not received training and did not have familiarity with this reporting system.

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 have met with them. Trainees are overall happy with the educational supervision arrangements and all levels of trainees reported that it is easy to get WBAs and SLEs completed.

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)
Core level trainees report that feedback was not given tactfully (at handover and ward rounds) and it was felt that most 'registrars' were not appreciative of the hard work done by core trainees.

Trainee Safety and Support (R3.2)
Core trainees did not feel appreciated by the senior medical staff. There was a unanimous view that there is a lack of an appreciative culture and this extended to some senior medical staff (consultants and 'registrars') and some nursing staff. Although there was no bullying or harassment reported, the culture was described as being negative. This was not a unit that trainees at this level would recommend to their peers.
ST3+ trainees felt supported by their consultants. More senior trainees who have worked in the unit for the time period predating Enhanced Monitoring report that the training experience has improved and that supervisors are more involved in training. The ST2/ST3+ trainees report that their TPD is extremely supportive and involved in their training and development.

Undermining (R3.3)

[redacted]

Study Leave (R3.12) and Annual Leave

The leave approval system involves the need for consultant approval and a single consultant in the unit has responsibility for this. Some trainees described that there has been a recent change in personnel and that the leave approval is not being sanctioned in a timely manner and this has had an impact on the ability to take leave that has been requested at least 6 weeks in advance.

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.

The visiting team did not meet with the trainers.

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.

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)

There has been progress reported by the limited number of trainees who had worked in this unit prior to the start of the Enhanced Monitoring process and there were no reports of any open disagreements between consultants from any of those we met. However, further work is required to address the culture in this unit so that it is supportive of education and training for all grades of trainees working in this unit.

Areas Working Well

1. **Unit Induction:** Unit induction programme works well.
2. **Hospital Educational Meetings** ongoing delivery of teaching programme despite COVID restrictions.
3. **F2/Core/ST Outpatient Experience.** All trainees attend clinics and report good supervision and learning experiences.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):

1. **ST3+ Practical Experience:** StRs describe good practical experience in theatre with an average of 4 theatre sessions per week.
2. **Support from Cardiothoracic TPD:** the StRs describe high level support from the TPD.

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:** Trust virtual induction appears to be satisfactory for those who attended, however, a number of the Core trainees did not attend and they have not previously worked in the BHSCT. All trainees reported that they had access to computer system passwords and possessed ID badges. Systems that track attendance would determine reason for this. Out of sync Trust induction should be offered to relevant trainees.	✓	✓	Amber
2. **Study Leave/Annual Leave:** The leave approval system involves the need for consultant approval and a single consultant in the unit has responsibility for this. Some trainees described that there has been a recent change in personnel and that the leave approval is not being sanctioned in a timely manner and this has had an impact on the ability to take leave that has been requested at least 6 weeks in advance. This system needs to be reviewed as a priority and whether having a single consultant holding responsibility for signing this off electronically is the most appropriate process.	✓		Amber
3. **EWTR Compliance:** On a Sunday evening the StRs when not rostered to work are expected to assess the patients that they will operate on the following day.		✓	Red

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. **Clinical supervision:** There is a reported lack of consultant presence at the early stages of surgery; however, middle tier doctors/ ST3+ are present. While ST3+ trainees do not feel they are working beyond their competency level, on direct questioning is was reported that there is not always a consultant in theatre. Starting theatre lists and participating in the WHO checklist is not common practice for all consultants.	✓	✓	Red
2. **Handover:** There is no single handover system (see Theme 1 R1.14). The ST3+ handover is not face to face or virtual. The intranet based patient list is used by ST3+ but not by all trainees.	✓	✓	Red
3. **Ward rounds:** Ward rounds are not consultant led on a regular basis especially for cardiac surgery patients. There is no Cardiac consultant described as being present at the morning virtual or the face-to-face ward round, the ST3+ leads this ward round and consultants see their own patients on an ad-hoc basis either daily or on alternate days towards the end of the working day.	✓	✓	Amber
4. **Practical Experience:** Core level trainees raised issues in relation to practical experience in theatre. Core trainees raised issues in relation to access to procedures which are currently being performed by SCPs. There is a lack of consultant presence at the early stages of the surgery to which the Core trainees should be gaining exposure. The department has reportedly moved to almost 90% endoscopic vein harvesting. However, no attempts appear to have been made for the trainees to learn or maintain this skill. Trainers need to consider what core and higher specialty trainees need to achieve and consider how this need can be met. Courses and an immersive experience for endoscopic vein harvesting have been used in other units.	✓		Red

5. **Practical Experience:** Core level trainees describe the balance of service to training for Cardiac cover as 98:2 and duties involved discharge summaries, phlebotomy and cannula insertion. There is no F1 cover for the cardiac unit. This will need to be addressed. There is no phlebotomy or Physician Associate presence in the Cardiothoracic unit and given the balance of non-educational duties undertaken some alternative needs to be scoped as a priority. The current system to determine what bloods have been done by nursing staff at night needs to be reviewed with a ward blood book or similar measure.	✓	✓	Red
6. **Practical Experience:** Providing care to ward patients is complicated by the varying practice among consultants and this lack of consistency is difficult for trainees. This results in uncertainty among trainees. Common management scenarios should be considered by the consultant teams as a whole and clear written guidance provided for all doctors and nurses. Unless there is some clinical reason for the variance the team should seek to develop consensus guidance for the unit as a whole.	✓	✓	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. **Clinical Supervision/ Trainee Safety and Support:** Some consultants are described by trainees as being unapproachable when contacted by telephone to discuss patient related issues. These interactions are described as difficult and although it relates to the minority of consultants it makes the trainees hesitant to call these individuals. Generally, the core level trainees would approach registrars in the first instance. This needs to be addressed. so that there is an understanding of the impact that their behaviour is having on trainees and additionally to communicate the expected response. This may require professional input so that insight to these behaviours can develop and coaching to modify the practice that is described. [redacted]	✓	✓	Red
2. **Trainee Safety and Support:** Core trainees did not feel appreciated by the senior medical staff. There was a unanimous view that there is a lack of an appreciative culture and this extended to some senior medical staff (consultants and registrars) and some nursing staff. Although there was no bullying or harassment reported, the culture was described as being negative. This was not a unit that trainees at this level would recommend to their peers. This needs to be addressed and consideration could be given to human factor training to include all levels of trainees, SAS doctors, consultants and nursing staff. The working environment described is not an environment that suggests a team culture or ethos.	✓	✓	Red