Obstetrics and Gynaecology Training

PLACEMENT QUALITY REVIEW
INTERIM REPORT MARCH 2019

Northern Ireland Medical and Dental Training Agency
REPORT COMPILED BY DR G BLAYNEY & DR S.A. PHILLIPS | 2019

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Executive Summary

This report details the review of the quality of training placements in the N.I Obstetrics and Gynaecology (O&G) Training Programme as carried out by the NIMDTA Placement Quality Improvement Work Stream which commenced in August 2018.

The first section of the report describes the background to the current O&G Review including the 2018 results of the GMC National Training Survey (NTS) and of the Royal College of Obstetrics and Gynaecology (RCOG) Training Evaluation Form (TEF) Report. This section also details the structure of the training programme within N.I and identifies unfilled posts and limited ST3+ training capacity as underlying issues.

The second section analyses the trainee feedback received from the Placement Quality Survey of Training in O&G and the associated Focus Groups (August/September 2018) and outlines the key recommendations for placement quality improvement.

The results are discussed under six headings.

I. Placement Preferences and Allocations
II. Induction and Rotas
III. Clinical Workload and Teaching
IV. Training and Supervision
V. Clinical commitments
VI. Overall Opinions

Key recommendations include:

1. Production of a Unit Prospectus for O&G Training in N.I;
2. Development of a regional O&G Training Leaflet to improve the information available for trainees in making career and placement choices;
3. Provision of unit rota allocations at least 6 weeks prior to post commencement;
4. Co-ordination of rotas by a permanent staff member, with appropriate job planning and time allocation;
5. Establishment of a regional 'Return to Work Course' for trainees after a prolonged time out of programme;
6. Provision of additional day time cover in emergency clinical areas and consideration of an elective caesarean section list in units where workload intensity is reported as excessive;
7. Delivery of 3 hours/week of protected (bleep free) in-unit teaching with consultant involvement;
8. Provision of a regional e-portfolio teaching update for trainers in O&G who are Education or Clinical Supervisors;
9. Improved utilisation of training opportunities on ward rounds, EPPC and ANCs
10. Development of regional written guidance for O&G supervisors from GP Lead Educators on specific training requirements for GP specialty trainees.

The final section highlights the recognised indicators of good quality training that all units should be aiming to achieve and defines a number of key actions to be taken forward.

Indicators of Good Quality Training units include:

- Trainee-centred where trainees are listened to, respected and valued;
- Good teamwork and clearly defined team structure;
- Recognised trainers who understand trainee needs, are appropriately trained and have dedicated time to supervise;
- Regular, weekly protected bleep-free teaching time with enthusiastic commitment of senior colleagues to teaching and training;
- Rotas issued in a timely manner and co-ordinated by a permanent member of staff.

Key actions going forward include:

- Resurvey of smaller O&G units to improve the confidence in the results where there are low numbers of trainees in units; Review of combined data by August 2019.
- Completion of meetings with educational leads in training units to identify and agree local improvement strategies by August 2019;
- Introduction of Deanery-wide improvement strategies (O&G Unit Prospectus and O&G Training Leaflet) by August 2019 and
- Resurvey of trainees January 2020.

Background

In the 2018-19 training year there were 87 posts in the Northern Ireland Obstetrics and Gynaecology (O&G) training programme, 42 ST1-2 level posts and 45 at ST3-7 level, which are spread over 9 hospitals (**WHSCT**: Altnagelvin Area Hospital and South West Acute Hospital; **SHSCT**: Craigavon Area Hospital and Daisy Hill Hospital; **BSHCT**: Belfast City Hospital (BCH) and Royal Jubilee Maternity Service (RJMS); **SEHSCT**: Ulster Hospital; **NHSCT**: Antrim Area Hospital and Causeway Hospital).

The School recruits a maximum of 12 ST1 trainees per year into a seven year Run-Through Training (RTT) programme. A total of 24 of the 42 ST1-2 level posts are therefore filled by O&G trainees in RTT leaving a surplus of 18 posts at ST1-2 level to be filled by Locum Appointments for Training (LATs). The remaining 45 posts aligned to ST3-7 training are sufficient to accommodate all trainees in the programme, taking into account factors such as maternity leave, less than full time training (LTFTT), out of programme and attrition from the specialty. The number of ST3+ trainees that the region can currently accommodate is limited to 9 posts per year due to the available training capacity.

There are an additional 23 O&G ST1-2 level posts identified as GP training posts with a further 14 Foundation Year 2 (FY2) doctor posts. This gives an overall total of 124 training posts associated with the O&G training units.

In August 2018 there were 74 O&G trainees in Northern Ireland, of which 9 were out of programme.

O&G training allocations are usually of 12 months duration with FY2 trainees having 4 month allocations and some GP ST1-2s having 6 month allocations. Some ST1-2 level posts are split across 2 sites (e.g. 6 months Daisy Hill Hospital, 6 months Craigavon Area Hospital within SHSCT). In the BHSCT all O&G trainees spend 6 months allocated to gynaecology in BCH (with ST3-7 trainees allocated to resident on call at RJMS) and 6 months allocated to obstetrics in RJMS.

The current attrition rate in the O&G training programme in N.I is 30% which is similar to the national UK average. The 2018 Royal College of Obstetrics and Gynaecology (RGOG) Workforce Review highlighted a poor work-life balance, bullying and undermining and lack of a team structure as possible contributing factors to the national figure.[1] Current methods of assessing the quality of O&G training posts include Deanery and GMC visits, the GMC National Training Survey (NTS) and the RCOG Training Evaluation Form (TEF) Report. Such national reports provide useful but at times limited information about individual training units. The need to further assess the quality of training posts is highlighted by the GMC's Promoting Excellence document, which states that organisations must have processes in place to monitor the quality of placements and that postgraduate training programmes must give a balance between providing services and accessing education and training opportunities.[2] To address this requirement NIMDTA has developed a Placement Quality Indicators (PQI) work stream. The primary aim of this work stream is:

'**To optimise patient-centred care though 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.**'

This Interim Summary Report details the review of the quality of training placements in the N.I O&G training programme as carried out by the NIMDTA Placement Quality Work stream. The report highlights the generic regional findings. Separately a detailed unit analysis will be presented to each unit individually in order to devise unit-specific strategies for improvement. The 2018 PQI review has produced a number of generic recommendations to improve the quality of O&G training and this interim report will be followed up with a final report in March 2020 following further trainee feedback.

GMC National Training Survey Results: O&G Training in N.I[3]

In the UK, O&G was cited as one of the training programmes with the least favourable trainee experience. In N.I the NTS response rate was reported at 99.88%. O&G training was generally rated within the white and green categories with many areas of good practice evidenced. For GP training in O&G 4 domains; supportive environment, curriculum coverage, local teaching and rota design were red flagged in the SEHSCT (Ulster Hospital) with a further 7 domains borderline satisfactory and 5 domains borderline for FY2 training; overall satisfaction, teamwork, supportive environment, curriculum coverage and educational supervision. In the SHSCT (Craigavon Area Hospital) supportive environment and study leave were highlighted as red outliers. For O&G training, the WHSCT and SEHSCT were borderline outliers for feedback. The BHSCT had 8 borderline domains for FY2 trainees in O&G; overall satisfaction, clinical supervision, teamwork, supportive environment, induction, adequate experience, curriculum coverage and educational governance with access to study leave as a red flag outlier.

Training Evaluation Form (TEF) Report: O&G Training in N.I[4]

In 2017 the overall TEF award winner in the UK was Antrim Area Hospital with Craigavon Area Hospital and the Ulster Hospital being 2 of the 9 units to receive high commendation out of a total of 171 units. [5]

The 2018 TEF report highlighted O&G training in N.I as third out of 16 deaneries in the UK with an overall satisfaction score of 80.7%. The WHSCT and NHSCT were highly commended on the basis of performance across a selection of TEF indicators. Overall, the N.I training programme ranked first in the UK for overall satisfaction and regional teaching – attributed to regular half day regional Continuing Medical Education (CME) sessions. N.I also ranked first for clinical governance, hospital procedures resources, working environment and basic obstetric ultrasound training. The N.I training programme was ranked in the top 6 for all the training domains assessed. Survey respondents agreed/strongly agreed that they had appropriate opportunities to fulfil training requirements in obstetrics (91%) and gynaecology (70%). This compared to the national average of 83% for obstetrics and 56% for gynaecology. Only 5% of N.I. trainees felt that work intensity was too high for training needs compared to the UK figure of 12%. The School of O&G, its Lead Educators and local education providers are to be commended for this achievement.

Nationally the TEF report highlighted that there are far more opportunities for obstetrics training than gynaecology. It is recognised that gynaecology theatre sessions can be overcrowded, restricting the opportunity for trainees to advance in gynaecological operating and that opportunities to attend specialist gynaecology clinics are often lacking. There is also evidence of considerable conflict between service provision and training in O&G. Nationally almost 30% of trainees reported that they had felt obliged to work beyond their contracted hours however over 80% felt that the workload was appropriate for their learning needs.

PQI review

Training Survey

The first stage of the O&G training PQI review involved background research into the current training structure within O&G in N.I and a review of the GMC NTS and RCOG TEF report data as detailed above. The RCOG O&G Curriculum training matrix was also reviewed.[6]

A detailed training survey for all trainees (GP and ST1-7/LAT 1-2) in O&G training posts was compiled and submitted for approval by the PQI review group to the Head of School and DHoS for O&G. The survey was disseminated online in August 2018 (via a Survey Monkey® link) and remained open for completion for a period of 3 weeks. Trainees were encouraged to complete the survey through emails from the NIMDTA O&G Executive Officer. A focus group was then conducted in October 2018.

The survey generated a 66.25% response rate (53/80). Of the total number of respondents 42 were O&G trainees (74% response) and a further 11 were GP trainees (48% response). There were responses from every training unit in N.I. and from all levels of trainees. Of note Daisy Hill Hospital (DHH) had only 3 respondents (100% response rate for this unit), SWAH had one respondent (100%) and Causeway had 1 respondent (33%). Due to the small numbers in these units a resurvey of current trainees in these units will be completed in January 2019.

Focus Group

For the second stage of the O&G training PQI review a focus group was conducted; 6 O&G trainees, ranging from ST1 to ST7 contributed. There was representation of male and female trainees, both QUB and non QUB graduates and within the group members had worked in every O&G training unit in N.I. Some trainees had had experience of prolonged periods out of programme.

Both the survey and focus group questions were split up into 8 categories.

1. Placement Preferences and Allocations
2. Induction and Rotas
3. Clinical Workload and Teaching
4. Training and Supervision
5. Clinical commitments
6. Overall opinions

1. Placement Preferences and Allocations

Information

Additional information about training posts prior to making their placement preferences was requested by 66% of trainees. Requests, in descending order of frequency, included

- average number of theatre sessions per trainee;
- amount of protected training time per trainee;
- details of specialist services offered in the unit;
- rota pattern;
- number of outpatient clinics per week;
- unit demographics;
- how much theatre time the gynae operating fellow would usually have and
- banding

Focus group attendees indicated that they would be keen on the option of a Unit Prospectus to aid them in their placement preference decisions. Two thirds of trainees gain information about potential posts from other trainees, highlighting the need for ongoing opportunities for trainees to interact through regional training, society meetings and social events.

Post Allocations

The need to allocate training posts based upon training needs was well recognised by trainees (91% of respondents). In addition 72% requested that personal preference and 43% that proximity to their home be taken into account.

Notification

Placement notification from NIMDTA is generally timely; 86% of trainees were notified by NIMDTA of their training post more than 6 weeks prior to commencing the post (38% > 8 weeks); but 4% of trainees received less than 4 weeks' notice.

Summary of Key Recommendations: Placement Preferences and Allocations

Information

- Production of a Unit Prospectus for O&G Training in N.I

In response to ongoing requests for more information about units to assist trainees in making their placement preferences a Unit Prospectus for O&G Training will be produced by NIMDTA, in partnership with Trust educational leads and will be accessible to all trainees on the NIMDTA website. This will provide information on each individual training unit, including their training strengths, to enable trainees to 'map' placement requests to their training needs. This prospectus will be based on contributions from trainees and consultants in individual units, detailing essential information about available training opportunities. This document will be reviewed annually.

- Production of O&G Training Leaflet

An information leaflet explaining O&G training in N.I will be produced by NIMDTA and will be made available for all trainees and prospective trainees on the NIMDTA website. This will provide a valuable resource for trainees new to the specialty or to Northern Ireland and will promote N.I. as an O&G training deanery to those considering a career in O&G.

- Timely Post Allocations

NIMDTA to ensure that all trainees receive notification of their training post more than 6 weeks prior to post commencement.

2. Induction

Appropriate unit induction with a clear understanding of individual roles and responsibilities within the post was reported by 76% of trainees however 17% of respondents were unclear of their roles and responsibilities. Unit induction was rated more highly than Trust induction, which respondents commented was often not relevant for O&G (e.g. hospital at night). GP trainees commented that a more thorough unit induction was needed as they have no prior experience of the specialty. From the focus group it was clear that the induction received was inadequate for trainees returning to work after a prolonged period out of programme (e.g. maternity leave, sick leave, research, fellowships), when the timing of this return did not align with the routine induction in August. Focus group attendees highlighted the potential benefits of having a return to work training course for trainees returning after a prolonged absence from the programme.

3. Rotas

Notification

Just over half of trainees were given less than 4 weeks notification about rota allocation by the Trust with 10% of trainees receiving notification on the day of commencing their post. Considerable difficulties were voiced regarding childcare provision and organising accommodation as a result of this very limited notice.

Rota Co-ordination

Within training units 66% of respondents stated that a trainee co-ordinates the weekly rota however 92% of respondents requested that a consultant or designated specialty doctor (not a trainee) should co-ordinate the weekly rota to ensure that the balance between service provision and educational requirements is maintained. Trainees expressed the opinion that a consultant or specialty doctor has the clearest understanding of the service needs of a unit and knows the best way to meet this service need whilst ensuring trainees' educational needs are being delivered. Respondents commented that a trainee coordinating the rota could have potential conflicts of interest and wouldn't know the unit as well as a permanent medical staff member. The focus group also highlighted this, suggesting that the rota was a thankless task with a very heavy workload and that trainees should not be responsible for other trainees.

Rota Gaps

Gaps on rotas existed in all training units. On the junior tier 72% of survey respondents indicated that their rotas were fully staffed (with trainees or long-term locum doctors), but 10% reported being requested to fill gaps in the on-call rotas. This was similar at registrar level with 68% of respondents reporting that rotas were fully staffed (with trainees or long-term locum doctors) and 11% of trainees reporting being asked to fill rota gaps. Trainees commented that rota gaps meant that theatre time was lost to cover clinics; service provision often took priority over training opportunities and in some units training was significantly compromised, due to insufficient numbers of doctors and an excessive workload. Focus group feedback highlighted that if locums were on the registrar rota they often didn't teach more junior trainees which significantly impacted upon training.

Summary of Key Recommendations: Induction & Rotas

Induction

- All trainees should receive an appropriate induction to the unit as highlighted by GMC's Promoting Excellence.[2]

The NIMDTA induction checklist is available online (http://www.nimdta.gov.uk/quality-management/meeting-gmc-standards/good-practice/) and is a useful tool in achieving this. This can then be signed by the employee and supervisor and retained for future reference.

- Return to Work Courses

The PQI review highlighted the need for return to work courses for trainees returning to work after a prolonged period out of programme (e.g. maternity leave, sick leave, research, fellowships). This could include a refresher of practical skills regarding obstetric emergencies, scanning, CTG and an update on the latest developments in O&G etc. The RCOG have very useful information on returning to work including a template for setting up a local 'Return to Work' Course. This is available at https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/return-work-toolkit/
The Head of School and DHoS are currently exploring the option for a regional 'Return to Work Course in N.I'.

Rota Co-ordination and Allocations

- Timely rota allocations
  - Rota allocations should be made available to trainees at least 6 weeks prior to post commencement
  - Named consultant/SAS doctor should co-ordinate this allocation, with appropriate job planning and time allocation

Each unit should receive details from NIMDTA of trainee postings approximately 8 weeks prior to posts commencing. Units should then aim to release rota allocations within 2 weeks of receiving this information (6 weeks prior to posts commencing). It is recommended that each unit should assess the potential for a permanent member of staff to co-ordinate the weekly rota (Consultant/SAS doctor). This person should ideally have dedicated PAs to allow for this and be contactable to resolve any rota issues (e.g. training requirements, sickness etc.).

Focus group members highlighted that this would be much fairer and would be expected in any other job. It would also assist in booking study leave / arranging accommodation/ making childcare arrangements in a timely manner.

4. Clinical Workload

Workload intensity at night and at weekends was reported by 29% of respondents as very intense or excessive with 25% reporting the same during the day. This varied significantly across individual units. Respondents highlighted that in some units there was good senior/consultant support when the unit was particularly busy. Suggestions for improvement from both survey free-text comments and the focus group included separate lists for elective caesarean sections and a second registrar on during the day in some units to assist with covering emergency clinical areas such as gynaecology ward referrals, the emergency obstetric unit or early pregnancy clinic. The majority of focus group attendees felt that their work was much more service provision than training. A senior trainee did however highlight that in one unit there was more training time and less service provision towards the end of training.

5. Teaching

Only 17% or respondents received 3 hours of protected teaching time per week and 46% reported less than 3 hours per month. The majority of teaching was not bleep-free and trainees were often called away to complete clinical duties. Most units have allocated local teaching sessions and 50% of trainees felt that these were interesting, relevant and occurring weekly but 14% of respondents reported that teaching sessions rarely or never had a consultant present. Respondents highlighted that audit, PDP and e-portfolio were usually completed in their own time, after a working day.

An active unit culture of research, poster and oral presentations was reported by 55% of trainees but 21% said there was no specific encouragement to undertake such activities.

The RCOG 2018 TEF report recorded the N.I. deanery as being the best training programme in the UK for regional teaching.[4] O&G trainees attended an average of 8 of the 22 scheduled Friday afternoon regional CME sessions with 2.3 of these occurring in their own time (outside of normal rostered working hours). Barriers to attending more sessions included morning activities running late (37%), commitments (outside of on call) in the base unit (23%) and on call commitments (74%). Focus group attendees commented that local teaching is not protected at all and is always at lunchtime. Effective teaching is prevented in some units by a very intense workload and the ongoing need for service provision. Trainees may also have to travel between different sites at lunchtime for clinical commitments preventing attendance. Local teaching is usually delivered by trainees and in some units consultant attendance at local teaching is low.

Summary of Key Recommendations: Clinical Workload & Teaching

Clinical Workload

- Elective Caesarian Section Lists

Where workload intensity is reported as excessive, particularly during the daytime, consideration should be given as to the feasibility of introducing an elective caesarian section list.

- Additional day time cover in emergency clinical areas

In units where workload intensity is reported as excessive during the day consideration should be given to allocation of an additional registrar or SAS doctor to assist with covering emergency clinical areas such as gynaecology ward referrals, the emergency obstetric unit or early pregnancy clinic.

Teaching

- Protected teaching time

In the N.I O&G training programme Friday afternoon has been previously identified as non-clinical time (aside from emergency on-call work). This allows trainees to attend regional CME sessions or local unit teaching. We highlight that O&G CME teaching in N.I was ranked top in the UK in the most recent RCOG TEF report.[4] It is noted however, that the current PQI review suggests that in some units this designated teaching time is not always being protected. Local teaching in some units is reported by trainees as less than satisfactory regarding frequency, quality, protection from service provision (bleep-free) and consultant attendance.

- All O&G trainees should be released from clinical duties to attend Friday afternoon regional CME teaching (aside from those providing emergency on-call cover).

- All training units should provide weekly, protected, bleep-free local teaching.

- There should be consideration given to allocation of SAS doctors to cover services (elective and emergency) during protected teaching time for trainees.

- Local teaching should be tailored to GP trainees/ FY2s when CME is on (when O&G trainees are therefore off-site) and should be targeted for all trainees when regional CME teaching is not scheduled.

- Local teaching should have a dedicated consultant attending or a consultant teaching rota.

6. Training & Supervision

Feedback on clinical and education supervision was generally positive and 100% of trainees felt that there should be recognition for supervisors who go above and beyond for trainees.

Supervision provided by Educational Supervisors (ES) was rated as excellent or above average by 67% of respondents, however 4% felt that supervision was poor and some commented that induction meetings were frequently late and that the ES was too busy to meet them.

Clinical supervision was generally good with trainees rating supervision as good/excellent in hours in 63% and out-of-hours in 57% of responses. In 2% of responses trainees had such significant concerns with clinical supervision that they felt it necessitated specific attention. In some units trainees felt supervision definitely could have been better on some days and there were some concerns expressed about reluctance of consultants to come in out-of-hours with junior registrars often needing to insist on consultant attendance in certain cases. Trainees reported also that better supervision would have been advantageous for e-portfolio and sign offs.

Focus group attendees commented that most supervisors need more training on how to be a supervisor including updates on how to use the e-portfolio. They also highlighted key qualities of an excellent clinical supervisor: approachable, attends daily handover, understands the unit and is 'hands on' during periods of increased work intensity. They also highlighted that a resident consultant out-of-hours may be beneficial in smaller units with only one registrar tier.

Summary of Key Recommendations: Training & Supervision

Supervision

- E-portfolio teaching update for trainers in O&G with a role as ES or CS

We note the planned introduction of a new GMC approved curriculum for O&G from the RCOG in August 2019. An update on e-portfolio training could be incorporated into the planned curriculum updates.

7. Clinical Commitments

Trainees were asked about attendance at various clinical activities in one year of training. This ranged from attendance at outpatient clinics to ward rounds, theatre lists and more specialist clinics such as Early Pregnancy Clinic (EPPC), Ultrasound scanning sessions and Advanced Training Specialty Modules (ATSMs) for senior trainees. Consultant attendance and training opportunities in each clinical area were also reviewed.

ST 1-2/LAT trainees generally reported good exposure to antenatal (ANC) and gynae outpatient clinics (GOPD) as well as gynae theatre (inpatient or day case), ward rounds and labour ward, however exposure to EPPC and Ultrasound sessions was poor. Training opportunities were missed regularly or often in half of EPPCs and 30-40% of ward rounds. Around 25% of respondents reported that less than half of all ward rounds had consultant supervision.

ST3-5 trainees reported good exposure to outpatient clinics but half indicated that a consultant was present at less than 80% of ANCs and consequently training opportunities were often missed. Theatre attendance was generally good with 40% of respondents getting to >25 theatre sessions per year. Staff shortages however often meant that trainees had to attend more clinics. A third of trainees attended no EPPC sessions and all ST3-5 trainees had less than 5 US sessions/year. Consequently training opportunities were regularly or often missed in ward rounds, ANC and EPPC.

ST6-7 trainees generally had good clinical exposure with 11-20 ATSM sessions/year. Dedicated US sessions rarely occurred and 44% did not attend any EPPC clinics. Again, training opportunities were often/regularly missed on ward rounds and ANC.

GP trainees felt they were getting good ward round experience but outpatient exposure varied between units. Training in GOPD was good but attendance varied considerably. Training was poorer however on ward rounds and at antenatal clinic.

Focus group attendees explained that training in outpatient clinics could certainly be improved, and often is better in peripheral units. They suggested intermittent consultant attendance at EPPC/US sessions solely for training purposes.

Summary of Key Recommendations: Clinical Commitments

Clinical Commitments

- Individual units to look at ways of improving training opportunities in Ultrasound and on ward rounds, EPPC and ANCs where trainees report most training opportunities are being missed.

- NIMDTA to discuss with GP Lead Educators the possibility of providing written guidance for O&G supervisors on training requirements for GP specialty trainees.

8. Overall opinions

Q: Please provide a global score for this placement as a training opportunity?

Excellent	27.5%
Good	40%
Acceptable	27.5%
Less than satisfactory	5%
Poor	0%

Positive comments from trainees included:

- Good emphasis on training junior trainees
- Great opportunities at ST2 levels to complete labour ward competencies
- Rota allowed lots of labour ward time
- Every effort made to make placement relevant for GP trainees
- Plenty of consultant presence
- Lots of theatre experience, very motivated for academia
- Consultants very keen to teach
- Steps to improve problems were taken when highlighted despite a challenging rota

Negative comments from trainees included:

- Competing with fellow for theatre lists
- Service provision took priority
- Little/no organised teaching in this unit
- Very poor Early Pregnancy and GOPD scanning opportunities
- All acute gynae ops done by consultants out of hours – no experience for tutors
- Poor teaching culture with poor consultant input
- Felt less valued than other posts
- Less clinic and theatre time and fewer opportunities to participate on labour ward than other units

We highlight that these comments are for units throughout the N.I training programme and that individual unit analysis will be presented to each unit separately in order to devise unit-specific strategies for improvement.

Placement Quality Indicators: Good Practice

The PQI review of O&G training has highlighted a number of indicators that signify good quality training, as detailed below. We would encourage every unit to aim to achieve these.

- Trainee-centred unit where trainees are listened to, respected and valued
- Teamwork and team structure, including teams that socialise together (e.g. having lunch together, social events etc.)
- Approachable senior colleagues who assist with service provision during periods of increased work intensity and are available for pastoral care
- Supervisors who understand trainee needs, are appropriately trained and have dedicated time to supervise
- Rotas - master rota released in a timely manner prior to commencing post (ideally 6 weeks prior) and weekly rota co-ordinated by a permanent member of medical staff and released in a timely manner
- Teaching – dedicated, protected, bleep-free teaching which is relevant, meeting trainee needs, occurring on a weekly basis and with full commitment by senior colleagues to teaching and training

The RCOG in the most recent TEF Awards highlights three points to consider in order to improve training in any unit: better team working; valuing, supporting and respecting trainees and putting training first – evidence links high quality training with high quality patient care. Furthermore they recommend a number of top tips to improve training units which can be accessed at: https://www.rcog.org.uk/en/careers-training/about-specialty-training-in-og/assessment-and-progression-through-training/training-data-analysis-2018/tef-awards-2018/

Actions going forward

This report will be circulated to all O&G trainees, lead educators, trainers and Directors of Medical Education (DMEs) in all training units in N.I. Individual unit analysis will be shared with each unit separately at meetings with college tutors, DMEs and clinical directors.

Key steps going forward include:

1. Discussion of the PQI Interim Summary Report and suggested improvement recommendations with Head of School, DHoS and School Board
2. Re-survey smaller units (SWAH/DHH/CAU) in January 2019 to improve validity of results as small number of trainees in initial survey
3. Completion of meetings with individual units by June 2019 to discuss improvement strategies.
4. Implementation of agreed improvement strategies (by August 2019)
5. Deanery-wide improvement strategies:
   a. N.I O&G Training leaflet – to be produced by NIMDTA (ADEPT fellow) and released via the NIMDTA website (March 2019)
   b. N.I O&G Unit Prospectus – contributions by consultants and trainees in each unit, editing by NIMDTA ADEPT fellow and review by Head of School and DHoS - for release onto the NIMDTA website (March 2019)
6. Comparative individual unit analyses to be circulated to lead educators after completion of unit visits.
7. Resurvey of trainees following implementation of improvement strategies.(January 2020)
8. Follow up progress report (March 2020)
9. Annual end of placement questionnaire to be devised and implemented to continuously review and maintain placement quality. For introduction by August 2020.

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Appendices

1. O&G Placement Quality Survey Questionnaire
2. O&G Focus group questions