NIMDTA
Deanery Visit to Western Trust
FINAL REPORT

Hospital Visited	**Altnagelvin Area Hospital, Western Trust**
Specialty Visited	**General Medicine**
Type of Visit	**Cyclical visit**
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr Dermot Hughes, Medical Director Dr Neil Corrigan, Director of Medical Education
Date of Visit	**19th April 2018**
Visiting Team	Dr Richard Tubman, Associate Dean (Chair) Ms Jackie Rendall, Head of School, Medicine Dr Emma Casey, GP Representative Mr Jonathan Patton, Lay Representative Dr Liam Convie, Trainee Representative Ms Emma Dickson, Quality Management Executive Officer, NIMDTA
Rating Outcome	**Red**: 3 / **Amber**: 1 / **Green**: 7
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 Altnagelvin Area Hospital.
Circumstances of this visit	The Deanery Visiting Team met with educational leads, trainees and trainers in General Medicine at Altnagelvin Area Hospital.
Relevant previous visits	Cyclical visit to General Medicine, Altnagelvin Area Hospital, 23rd November 2012
Pre-visit meeting	9th 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 23rd November 2017 and subsequent Trust Action Plan Trust Background Information Template 9th April 2018 Pre-visit SurveyMonkey® April 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

Dr Damien Armstrong, Foundation Programme Director (on behalf of Dr Neil Corrigan, Director of Medical Education)
Dr Girish Shivashankar (Educational Lead for ST trainees)
Dr Stephen Todd (Educational Lead for CT trainees)
Dr John Corrigan (outgoing College Tutor; Educational Supervisor)
Dr Dermot Hughes, Medical Director

Trainees Interviewed

	F1	F2	CT1/2, GPST, ST1-2	ST3+
Posts	14	10	3 CT1/2, 3 GPST1, 1 ST1 (ACCS EM)	9
Interviewed	15 (current and past F1)	6 (current and past F2)	1 GPST1, 2 CT1/2	1

Trainers Interviewed

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Feedback provided to Trust Team

Dr Dermot Hughes, Medical Director
Dr Damien Armstrong, Foundation Programme Director (on behalf of Dr Neil Corrigan, Director of Medical Education)
Dr Girish Shivashankar (Educational Lead for ST trainees)
Dr Stephen Todd (Educational Lead for CT trainees)
Ms Sinead Doherty, Senior Manager, Medical Education
Dr Neil Black, Associate Medical Director
Mr Mark Gillespie, Assistant Director Acute Services

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

Dr Dermot Hughes, Medical Director
Dr Neil Corrigan, Director of Medical Education
Dr Damien Armstrong, Foundation Programme Director

Background

Organisation:
Altnagelvin is a large, busy District General Hospital. Undifferentiated medical admissions come through the Acute Medical Unit from the ED and local GPs. There are subspecialties in Cardiology, Rheumatology, Gastroenterology, Respiratory Medicine, Care of the Elderly, Neurology, Nephrology, Palliative Care, Dermatology and Rehabilitation Medicine. The medical wards are grouped by specialties. There are step-down and rehab beds in the Waterside Hospital.
The visit team were told of improvements in the number of doctors on the first and second tiers out of hours. There are plans to extend Hospital At Night (H@N) to weekends.

Staff:
There are 41 consultants across the range of sub-specialties. There are 8 specialty doctors. There are 9 ST3+, 1 ST1 (ACCS EM), 3 CT1/2, 3 GPST, 10 F2 and 14 F1 posts in Medicine.

Other Sites: N/A

NTS 2017:
There were red indicators for overall satisfaction, adequate experience, induction and study leave for F2 and for Educational Supervision for CMT.
The 2018 NTS is currently open.

Pre-visit SurveyMonkey:
There were 12/40 responses to the January 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)
All trainees said that the Trust induction was comprehensive and informative. Badges and passwords were given out very promptly. There were also two half days that covered specific specialty-based items. There is a range of information on the Trust's MDE app.

Unit Induction
F1: F1 trainees said that they did not in general receive a local induction or walk-round. They received their one-year rota two weeks before starting, which they really appreciated. There had been some difficulties with it in the first weeks but those have been resolved.
F2: F2 trainees also said that ward induction was variable.
CT/ST3+: Trainees were happy with the specialty-based induction given at the start of their post.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
F1: F1 trainees said that they were supervised well by F2, CT and SpRs at all times. H@N provided good support out of hours.
F2: F2 trainees said that clinical supervision was generally good. They described cover at Waterside hospital where there were rehab and subacute patients, which was provided on a weekly rotational basis by F2/GPST/CT. A consultant came in one day per week but they were there on their own as the most senior doctor for the rest of the time. They could phone a consultant for advice but they said that sometimes it was not clear which consultant was responsible for some of the rehab patients. Subacute patients could occasionally get quite unwell or need to be returned to Altnagelvin Area Hospital. Patients were covered by a local GP practice out of hours.
CT/ST3+: Trainees said that they were well supervised at all times. There were often a large number of subspecialty consultants in the hospital at weekends.

Handover (R1.14)
F1 trainees said that they do not attend the morning handover. The F1 trainee presents patient cases at the 9pm H@N handover. This is a formal handover and they can get feedback if they ask for it. Consultants rarely attend the 9pm handover.
F2 trainees reported that the morning handover was at 9am and was attended by F2/CT, registrars and consultants from the overnight and day teams. It was purely a business handover. The 9pm handover was led by the registrar and there was sometimes some teaching.
F2 trainees said that there didn't seem to be a formal system for tracking patients. Outliers were notified to them by the ward nurses.

Practical Experience (R1.19)

F1: F1 trainees started work at 9am. They spend the first one to two hours taking blood samples, although there is a phlebotomy service. They do ward tasks that are generated by the ward sister or core trainees. Most wards have job lists which F1 work from (not in CoE). They do not attend ward rounds apart from in AMU (nurses do the bloods there). They insert cannulas, order tests and do discharge letters (up to six to eight daily, 10-12 in cardiology). They can clerk in elective admissions in cardiology.

F1s said that they "were not learning anything in the wards" and that they felt that the F1 post in medicine did not prepare them well for being an F2 trainee in medicine next year. One said that they were "just a job monkey".

F2: F2 trainees said that they cover many of the wards during the day. They can attend consultant ward rounds which were interesting and educational. They have a rostered admissions shift in ED on different days where they can clerk in and triage patients. They share out some of the ward duties during the day with the F1 trainee. They were not able to get many practical procedures apart from some pleural procedures. They were assigned to a clinic week but they said that there was not much encouragement to get to clinics (contrasted with their time in general surgery), and that they struggled to get a room in outpatients. They reported that some consultants did not want juniors in clinics although others would let them see and present patients there.

GPST1/CT: CT trainees attended consultant ward rounds. They saw patients on the wards and clerked in patients either electively in cardiology or acutely as part of their admission shifts in ED. They were able to do some procedures including DCC, LPs, etc. They were happy that they could perform the required procedures.

GP and CT trainees were rostered to a clinic week once in six months. However this was of little or no benefit because they often had to cover the wards, and when they did get a chance to get to clinic there was not enough room available for them to see patients. They could sit in and observe only.

ST3+: ST3+ reported that they get a balanced mix of training opportunities. They attend consultant ward rounds and do their own ward rounds. There are opportunities for relevant practical procedures. They attend clinics regularly with the consultant.

Workload (R1.7, 1.12)

F1: F1 trainees said that their workload by day depended on what ward they were in but was in general manageable. The respiratory ward was particularly busy and there were often many outliers. Weekends were busy but there was now a locum F1 trainee whose job was solely to provide phlebotomy – this was an optional paid job and they were under no obligation to do it. This helped take some of the pressure off the F1 trainees, although the locum was filled by the F1s themselves. F1s said that the nurses asked them to do many "useless tasks" at the weekend.

F2: F2 trainees said that their workload by day varied but was manageable; it was busy out of hours but the registrars were very supportive.

CT/ST3+: Trainees said that their workload was manageable at all times.

EWTR Compliance (R1.12e)

F1, F2 are band 1a. CT and SpR said that their rotas were compliant and that they got away at the end of a shift on time.

Hospital and Regional Specialty Educational Meetings (R1.16)

There is Foundation teaching on Tuesdays and Postgraduate teaching for the whole hospital on Thursdays. There were also opportunities for teaching in some wards. Teaching was in general of a good standard and attended by consultants. F2s said that they got to most of the generic skills sessions in Belfast.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)

There are good educational resources on site. The Wi-Fi system is good. F1s said that they were offered simulation activities but were often too busy to attend. One trainee had been bleeped out of a simulation session by the ward sister to do discharge letters. F2 trainees said that there seemed to be a greater use of simulation with undergraduate students and they would like to see it used more for postgraduate trainees too.

Quality Improvement and Audit (R1.3, 1.5, 1.22)

Trainees are encouraged to take part in the First Steps and Step West programmes.

Patient Care (R1.1, 1.3, 1.4)

Trainees commented that there was a high turnover of nurses in Ward 20 (renal/cardiology), this resulted in some nurses being less skilled in looking after cardiology patients.

Patient Safety (R1.1-1.5)
Trainees reported that there was a patient safety culture within the Trust. Most trainees said that they had not used Datix and would like further training in its use.
F2 trainees described the interim results of a QI project on tracking outliers, which had not yet been formally presented. This had identified 7 outliers who had been "missed" over a 2 week period.

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.
F2s said that there was often a delay of up to a month in being allocated to a named clinical supervisor on TURAS.

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 are usually able to get informal feedback if they ask for it. This might be on the wards, at handover or in clinic (if ST3+).

Trainee Safety and Support (R3.2)
F1, F2, CT, GPST are still termed "SHO" by nursing staff, despite all having specific coloured lanyards to identify their grades.
F1 trainees described a number of colleagues who had received needle stick injuries from a new venepuncture system. They said that the nurses had been trained in its use but that F1s and phlebotomists (who took most of the blood samples between them) had not.
Trainees of all grades were concerned by the absence of security staff on site. A trainee described how they had been physically assaulted by a delirious patient. F1s said that they were always the first to be called when ward patients became violent or aggressive, although they were not prepared in any way to respond to these situations.

Undermining (R3.3)
X

Study Leave (R3.12)
F2s described what they saw as unnecessary delays in getting study leave approved. They were concerned that they could not get funding or support to attend a Basic Surgical Skills course which they said was necessary to complete in order to be able to apply for Core Surgical training.

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)
Clinical and educational supervisors are motivated, trained and well supported.

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)
There was a disappointing response rate to the pre-visit SurveyMonkey questionnaire. Attendance at the visit by CT and ST3+ trainees was extremely low and very disappointing.

Areas Working Well
1. Trust induction is comprehensive; badges and passwords are provided in a timely manner. **2.** Clinical supervision is good in Altnagelvin Hospital, particularly out of hours. **3.** The H@N handover works well. F1s can present patients at the meeting. **4.** F1 trainees are well supported by the H@N team. **5.** F2 and CT trainees do admission shifts in ED, which allows them to clerk in patients and initiate management. **6.** Local teaching is generally of a good standard. **7.** Trainees appreciate the provision of accommodation or a travel allowance by the Trust. **8.** Clinical and educational supervisors are motivated, trained and well supported.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. Trainees are encouraged to take part in the First Steps and Step West programmes.

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. Ward induction for foundation doctors is variable. An introductory tour of the department would be beneficial and should be built into future inductions.	✓	✓	Amber
2. Educational Resources. Trainees have difficulty accessing simulation opportunities. We would encourage developments in this area to continue.	✓		Green
3. Patient Safety. Most trainees said that they had not used the Datix system and would like further training in its use. We would encourage developments in this area to continue.	✓	✓	Green
4. Trainee Safety and Support. F1, F2, CT, GPST are still termed "SHO" by nursing staff, despite all having specific coloured lanyards to identify their grades. We would strongly encourage dialogue with nursing staff to develop an understanding of the different grades of trainee doctor, and their relevant competences.	✓	✓	Amber

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. Practical Experience. F1 trainees rarely attend ward rounds except in AMU. They work out of ward books except in the CoE ward. Their duties in daytime hours are largely administrative. They do not attend a morning handover. They do not feel the post prepares them adequately for F2.	✓	✓	Red
2. Patient Care. Trainees were concerned about the high turnover, and therefore the specialist skills, of nurses looking after cardiology patients in Ward 20. <u>This has been shared for information only.</u>		✓	N/A
3. Patient Safety. Trainees described their concerns about the number of outlying medical patients who had been "missed" for some time. Patient tracking within the hospital appears to be of variable efficiency. This has		✓	N/A

been audited recently. <u>This has been shared for information only.</u>			
4. Educational Supervision. F2 trainees said that there was often a delay of up to a month in being allocated to a named clinical supervisor on TURAS.	✓		Green
5. Practical Experience. F1 trainees reported that they are asked by nurses to do many unnecessary tasks at the weekends. This could be organised more efficiently and might benefit from an audit of activity.	✓		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. GP and CT trainees very rarely attend outpatient clinics. There is insufficient clinic space for them to see patients, and their role is observational only. They are very unlikely to get to enough clinics to meet the mandatory requirements of their curricula. This must be addressed as a matter of priority if the post is to continue to be suitable for Core Medical or GP training.	✓	✓	Red
2. Clinical Supervision. Cover for Waterside hospital is provided on a weekly rotational basis by F2/GPST/CT. A consultant comes in one day per week but F2 trainees would be there on their own as the most senior doctor for the rest of the time. They could phone a consultant for advice but they said that sometimes it was not clear which consultant was responsible for some of the rehab patients. Subacute patients could occasionally get quite unwell or need to be returned to Altnagelvin Hospital. Please see GMC Promoting Excellence 2026, Requirement R1.8 "*Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session.*" This serious concern was conveyed to the management team on the day of the visit. The Medical Director gave an assurance on the day of the visit that F2 trainees would no longer be the most senior doctor at the Waterside Hospital.	✓	✓	Green
3. Trainee Safety and Support. F1 trainees described a number of colleagues who had received needle stick injuries from a new venepuncture system. They said that the nurses had been trained in its use but that F1s and phlebotomists (who took most of the blood samples between them) had not.		✓	Red
4. Trainee Safety and Support. Trainees of all grades were concerned by the absence of security staff on site. A trainee described how they had been physically assaulted by a delirious patient. F1s said that they were always the first to be called when ward patients became violent or aggressive, although they were not prepared in any way to respond to these situations. This serious concern was conveyed to the management team on the day of the visit.	✓	✓	N/A
5. Undermining. X	✓	✓	Red

Summary Rating Outcomes		
Red	**Amber**	**Green**
3	1	7