NIMDTA
Deanery Visit to Western Trust
FINAL REPORT

Hospital Visited	**South West Acute Hospital, Western Trust**		
Specialty Visited	**General Medicine**		
Type of Visit	**Enhanced Monitoring visit**		
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr Dermot Hughes, Medical Director Dr Neil Corrigan, Director of Medical Education Prof Ronan O'Hare, Associate Medical Director, SWAH		
Date of Visit	**12th March 2018**		
Visiting Team	Dr Richard Tubman, Associate Dean (Chair) Ms Angela Carragher, Director for the Foundation Programme Dr John Harty, Foundation Programme Representative Mr Allen McCartney, Lay Representative Mr Robin Benstead, GMC Representative Ms Karen Moore, Foundation Training Coordinator, NIMDTA		
Rating Outcome	**Red**	**Amber**	**Green**
	2	**2**	**2**

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 General Medicine training at South West Acute Hospital.
Circumstances of this visit	The Deanery Visiting Team met with educational leads, trainees and trainers in General Medicine specialty at South West Acute Hospital.
Relevant previous visits	Cyclical visit to General Medicine, South West Acute Hospital, 23rd November 2012
Pre-visit meeting	26th February 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 13th December 2012 and subsequent Trust Action Plan Trust Background Information Template 12th February 2018 Pre-visit SurveyMonkey® March 2018, and post-visit repeat limited survey for F2 only, March 2018 GMC National Training Survey 2017 Western Trust mid-year quality report to NIMDTA March 2018
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 Keegan
Dr Sreenivasan

Trainees Interviewed

	F1	F2	CT1/2, GPST
Posts	9 (medicine)	4	4 CT, 1 GPST1
Interviewed	5 (medicine), 4 (surgery)	1 The post-visit SurveyMonkey was completed by all 4 F2	4 CT1

Trainers Interviewed

5

Feedback provided to Trust Team

Dr Dermot Hughes, Medical Director)
Dr Neil Corrigan, Director of Medical Education) by video link
Ms Sinead Doherty, Senior Manager Medical Education)
Dr B Keegan, Specialty Education Lead
Dr Sreenivasan
Dr Manley
Dr Granell
Dr O'Hare
Ms Christine McGovern, Senior Administrative Coordinator

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 B Keegan, Specialty Education Lead

Background

Organisation:
The General Medicine department in South West Acute Hospital (SWAH) is a busy unit, looking after undifferentiated general medical admissions, with specialism in cardiology, gastroenterology, Care of the Elderly (CoE), Stroke, and respiratory medicine.
We were told that since August 2017, the out of hours rotas now include an F2 rota and an "F2+" rota. This latter is

made up of CT/GPST/locums/IMG doctors. The Trust has funded an extension to the hours of Hospital at Night (H@N). There has been an expansion in the numbers of consultants.

Staff:

There are 16 consultants, some of whom are locums. There are 4 specialty doctors. There are 7 CT1/2 (2 vacant), 2 GPST1 (1 vacant), 4 F2 and 9 F1 trainee posts. There are an additional 7 locum doctors at F2+ level appointed by Trust to assist with 3 CT/GPST vacancies, and the 4 F2 posts held pending enhanced monitoring outcome.

Other Sites: N/A

NTS 2017:

There were green indicators for adequate experience and curriculum coverage for F1 trainees.
There was a red indicator for reporting systems and pink indicators for overall satisfaction, clinical supervision, clinical supervision out of hours, teamwork, supportive environment, induction, feedback and study leave for F2 trainees.
For the GIM post overall, there were recurrent red indicators for clinical supervision and clinical supervision out of hours, and red indicators for work load, regional teaching and study leave.
We are aware that the 2018 NTS is now open.

Pre-visit SurveyMonkey:

There were 9 respondents (including 5 F1 trainees). There were concerns that F1 trainees did an imbalance of service vs training. Three respondents reported undermining by nurses, including being called derogatory names.

Previous Visits/Concerns:

1. The cyclical visit in 2012 identified concerns about:
   - The F2 trainee was often the most senior doctor present at night in the hospital
   - The F1 training experience was not good, with a large number of tasks of limited educational value. This had been highlighted at a previous visit in 2009 but not addressed by 2012.
   - Workload for F1 trainees was very intense at weekends; it was suggested that expanding the H@N format during weekends would help.
2. Concerns published by the GMC (NID1012-28): "As part of the Northern Ireland national review, the GMC visited Western Health and Social Care Trust on the 28 February 2017, at which the team raised a serious concern with supervision out of hours for foundation doctors in training. This issue had previously been identified by NIMDTA and was reported to the GMC via the Dean's Report process and was being monitored. We found that foundation Year 2 doctors at South West Acute Hospital (SWAH) to be the most senior doctors out of hours on the acute medical take. They were able to call consultants who were off site, but did not have access to on-site supervision, and we heard examples where doctors in training were left in vulnerable situations. Western HSCT and NIMDTA provided an action plan which is being monitored by NIMDTA. A GMC supported deanery revisit is scheduled for March 2018. We will continue to provide NIMDTA with enhanced monitoring and support until we have evidence that the issues have been resolved and the changes are sustainable."

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)

F1: Three of the F1 trainees that we spoke with had done their F0 training in SWAH, and said it was very useful. F1 trainees said that the Trust induction was good, and that they were provided with a booklet and DVD beforehand. The induction on the first day was by video link to Altnagelvin Area Hospital, which worked well. They were given a teaching session on the hospital computer systems by one of the IT staff, whom they praised. There were no significant delays in getting computer passwords or ID badges.
F1 trainees reported that there "was no induction to the medical wards" but that it was very good on the surgical wards. They said that they had not received any induction to cross-covering out of hours.
Trainers however reported that local induction to the medical wards was provided to those trainees who had not

done their F0 training in SWAH by one of the staff grades. They reported that there was no cross-cover induction but that F1 trainees were very closely supervised by the H@N team.
F2 and CT: Trainees said that their induction was good. They were told what their duties were, how to contact someone more senior when on-call, etc. CT trainees reported that they would appreciate more information on how they should interact with GPs.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
F1: F1 trainees reported that they were well supervised both during the day and out of hours. They had very close support from the H@N team to 1 am.

F2: There was only one F2 trainee present on the day of the visit. As a result, NIMDTA issued a Survey Monkey questionnaire specifically on clinical supervision to all four of the F2 trainees after the visit.
Their anonymous responses were as follows:

- Global score for clinical supervision: 4/4 "acceptable"-"excellent"
- Supervision during working hours, when on-call and out of hours: 4/4 "acceptable"-"excellent" for all times
- Do you know who to call for support or advice at all times? 4/4 "Yes"
- Are consultants accessible/responsive when you contact them? 4/4 "Yes"
- Have you on-site access at all times to a suitably experienced senior colleague? 3/4 "yes" (comment: "No registrar/consultant in the hospital at night, available for advice if contacted.")
- Have you been supervised clinically by someone whom you felt wasn't competent to do so? 4/4 "No"
- Have you felt forced to cope with clinical problems/make decisions/carry out procedures beyond your competence or experience? 4/4 "No"

F2 trainees said that they were always working alongside a CT trainee "or similar" out of hours. There was said to be variable support from the ICU out of hours.

CT: CT trainees reported that they were well supervised by consultants. There is no middle grade tier out of hours.

Handover (R1.14)
Trainees reported that F1 handover in the morning consisted of peer-peer bleep handover. In contrast, F1, F2, CT, H@N staff, the bed manager, the ED Consultant and usually the on-call medicine consultant attended the 9pm H@N handover. This was said to be thorough and discussed all sick or admitted patients.
On Fridays the F2 trainee prepared a list of patients needing weekend review.
CT trainees reported that morning handover was face-to-face with the consultant and daytime CT. This was of variable usefulness, compared to the H@N handover, which they described as "really good". There was a post-take ward round at 7.30am.

Practical Experience (R1.19)
F1: F1 trainees were ward-based rather than team-based. F1 duties during the day were limited to largely administrative tasks, inserting cannulas and taking blood, and were described as "not great" by the F1s. They took bloods between 9-11 am, and then did ward tasks including writing up Kardexes, and doing discharge letters (up to 8-9 per day). They reported that they often did not know much about the patients whose discharge letters they were writing, so had to spend a lot of time going through the notes.
F1 trainees reported that they did not do many patient clerk-ins and very rarely went on ward rounds except opportunistically. They did not get to learn much about clinical decision-making during the day.
There appeared to be a culture amongst nursing staff that certain duties, such as phlebotomy, were solely F1 trainee jobs. There is no hospital phlebotomy service.
F1 trainees worked from a ward job list, they reported that there was not much communication between them and the nurses; with the nurses sometimes writing in tasks to the book while the F1 was there, rather than discussing the task with them.
F1 trainees said that pharmacy support was excellent.
By contrast, F1 trainees said that they enjoyed working out of hours as they got good exposure to patients and good clinical experience working alongside more senior colleagues.

F2: F2 trainees said that they learned a lot during this placement. They took part in ward rounds, did patient reviews in care of the elderly, did patient clerk-ins and took requests for admission from GPs, H@N and the ED.
F2 trainees said that they did not get any opportunities for carrying out practical procedures as these were done in the acute medical assessment unit by the staff grades or consultants, or by the CTs out of hours.

CT: CT trainees rotated through a team-based allocation. They attended consultant ward rounds and did reviews. They saw new patients when they were the on-call CT. They were able to do some procedures, if available. CT trainees rotated through a variety of clinics for 2 weeks in 14; these included GI, cardiology, CoE and movement disorder clinics.

Workload (R1.7, 1.12)

F1: F1 trainees reported that they were always busy during the day because of the number of blood tests, which they said were generated by the nurses. Their out of hours work could be busy but medicine bleeps were first triaged by the H@N team until 1 am. They were bleeped directly by the surgical wards and by the medical wards after 1 am. F1 trainees said that they would welcome an extension of the H@N service through the night.

CT: CT trainees reported that consultants appropriately supervised them at all times.

EWTR Compliance (R1.12e)

All trainees said that their rotas were compliant and that they usually got away on time at the end of a shift.
CT trainees reported that their rota was made out by one of the Staff Grade doctors, and that they would appreciate having more input into its design.

Hospital and Regional Specialty Educational Meetings (R1.16)

Trainees reported that there is regular teaching for all staff, 2-3 days per week. It was said to be good and consultants attend regularly.
Teaching was "not normally bleep-free". Trainees described a pilot of bleep-free teaching, which had worked well, but they reported that the nurses took down the posters in the wards advertising the pilot.
F2 trainees reported that there were no difficulties getting to generic skills teaching at NIMDTA.

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

Trainees reported that there were good educational resources (including simulation) within the hospital. There were two teaching fellows, who contributed to a lot of the education.

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

Trainees reported that they had been offered a number of audit projects. They were encouraged to attend M&M meetings in medicine. They had been told about the "First Steps" leadership programme within the Trust.

Patient Care (R1.1, 1.3, 1.4)

Trainees reported that in their view the quality of patient care in General Medicine in SWAH was generally good. F2 trainees were able to provide continuity of care and felt listened to by the consultants. F1 trainees sometimes found it difficult to talk to relatives about patients because they did not get to attend ward rounds.

Patient Safety (R1.1-1.5)

F1 trainees reported that the use of job lists did not adequately communicate important issues about patients to them.
Trainees knew about the Datix system and some had used 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 all had a named educational supervisor and had met with them to agree a plan for their posting. Some of the F2's educational supervisors were in Altnagelvin Area Hospital, but they planned to meet them when they rotated to there. They were able to access workplace-based assessments. This was easier to do out of hours for DOPS.

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)

F1 trainees reported that the pharmacists would give them immediate supportive feedback about their prescribing if there were any issues.

CTs received a variable amount of feedback on the post-take ward round in the morning.

Trainee Safety and Support (R3.2)

No concerns reported

Undermining (R3.3)

X

Study Leave (R3.12)

No issues reported.

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 reported that they felt well supported in their roles.

They said however that that there were still ongoing issues with job planning in the Trust. They reported that they had not yet received any additional funding for their educational roles.

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.

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 were pleased to learn of the progress that the Trust have made in responding to the concerns raised by the GMC. F2 trainees are no longer the most senior doctor in the hospital out of hours. This is a work in progress and will require ongoing quality monitoring by the Trust and NIMDTA. We were very disappointed that due to leave and shifts, only one of the four F2 trainees was present for the visit, given that the reason for enhanced monitoring was concern about clinical supervision of F2 trainees.

Areas Working Well
1. F2 trainees reported (by questionnaire) that they are well supervised clinically by a more senior doctor at all times. **2.** The F0 placement is well-received by incoming F1 doctors. **3.** Trust induction is well-run and comprehensive. **4.** The 9pm H@N handover is well run and efficient. **5.** CTs are team-based, with a rotational allocation of duties that allows a good range and number of clinics. **6.** F1 trainees greatly appreciated the support given to them by pharmacists on the wards. **7.** Trainees are encouraged to carry out audit/QI projects and to apply for the First Steps leadership programme.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. F1 trainees valued the IT training support given specifically to them on starting in SWAH. **2.** F1 trainees are well supported by the H@N team from 5pm-1am. We would encourage the extension of H@N through the whole night.

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. Departmental induction for F1 trainees, including arrangements for cross-cover out of hours should be reviewed, taking into account feedback from current F1 trainees.	✓	✓	Amber
2. Handover. Morning handover is mostly ad hoc and compares poorly with the excellent night handover. A structured morning handover is a good opportunity for feedback to trainees and learning.	✓	✓	Amber
3. Local Teaching. The bleep-free teaching pilot worked well and should be embedded in practice. This must be respected by nursing staff.	✓		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. Practical Experience. F1 clinical experience is largely administrative or linked to tasks of limited educational value (this was flagged up in 2009 and 2012 and has not improved since then). They rarely attend ward rounds or complete patient clerk-ins. Their ward work appears to be decided mainly by nurses, and they work from a jobs book. This must be addressed urgently at senior Trust level and rectified. The working relationship between F1 trainees and nurses is unhealthy in some wards. There does not appear to be effective team-working, rather an "us-and-them" culture. There appears to be unwillingness by nurses to help with	✓	✓	Red

phlebotomy and cannula insertion. This should be addressed as effective team-working is central to a positive educational environment and to good clinical care. There is at times poor communication between nurses and F1 trainees, evidenced by the use of a jobs book rather than face-to-face discussion of tasks and the reasons for them. This could potentially result in a patient safety issue. **The Deanery QM group have agreed to merge items 1, 2 and 3 (as listed on the interim report) as all relate to F1 practical experience. These items will be merged with the existing item in the GMC Online Dean's Report.**			

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. Undermining. X	✓	✓	Red
2. Trainer Support. Trainers reported that they had not yet received any additional funding for their educational roles. This must be resolved.	✓	✓	Green

Summary Rating Outcomes		
Red	**Amber**	**Green**
2	2	2