NIMDTA
Deanery Visit to South Eastern Trust
FINAL REPORT

Hospital Visited	**Lagan Valley Hospital, South Eastern Trust**		
Specialty Visited	**General Medicine**		
Type of Visit	**Cyclical Visit**		
Trust Officers with Postgraduate Medical Education & Training Responsibility	Mr Charles Martyn, Medical Director Dr Craig Renfrew, Director of Medical Education		
Date of Visit	**10th May 2018**		
Visiting Team	Dr Richard Tubman, Associate Dean (Chair) Dr Jackie Rendall, Head of School, Medicine Dr Pat Manley, Foundation Programme Representative Mr Peter Gregg, Lay Representative Ms Emma Dickson, NIMDTA Representative		
Rating Outcome	**Red**	**Amber**	**Green**
	0	0	3
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 Lagan Valley Hospital.		
Circumstances of this visit	The Deanery Visiting Team met with educational leads, trainees and trainers in General Medicine specialty at Lagan Valley Hospital.		
Relevant previous visits	Cyclical visit to General Medicine, Lagan Valley Hospital, 9th November 2012		
Pre-visit meeting	2nd May 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 9th November 2012 and subsequent Trust Action Plan Trust Background Information Template 21st March 2018 Pre-visit SurveyMonkey® May 2018. GMC National Training Survey 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 Rosemary Kelly, Foundation Programme Director LVH (FPD)

Trainees Interviewed

	F1	ST1 ACCS (EM)	CT1/2
Posts	8	1	6
Interviewed	6	1	3

Trainers Interviewed

Dr Kelly
Dr Au
Dr Crawford
Dr Michael Alcorn
Dr Dunseith (SAS)
Dr Armstrong

Feedback provided to Trust Team

Dr Renfrew, Director of Medical Education (DME)
Dr Harding, Clinical Director
Mr Spratt, Senior Operations Manager
Mr Magill, Senior Manager, HR
Dr Kelly, Foundation Programme Director (FPD)

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

Dr Craig Renfrew, DME
Dr Rosemary Kelly, FPD (LVH)
Dr Tim Harding, Clinical Director, Medicine

Background

Organisation:
Lagan Valley Hospital (LVH) is a local hospital that provides inpatient and outpatient medical services, including GIM, respiratory medicine, cardiology, gastroenterology and care of the elderly (CoE). There are two medical wards and a care of the elderly frailty/stroke unit. Medical patients are mostly admitted via the ED, which is open from 8.00am-8.00pm, Monday to Friday. The department is about to set up an enhanced care at home/rapid access to care for CoE patients.

Staff:
There are seven consultants, three AS/specialty doctors, six core medical trainees, one ACCS (EM) trainee and eight F1 doctors.

Other Sites:
N/A

NTS: 2017
There were green indicators for workload, teamwork, supportive environment, induction and educational governance for F1, and green indicators for clinical supervision out of hours, workload, induction, educational governance, local teaching and study leave for CMT.

Pre-visit SurveyMonkey:
6/15 trainees responded to the 2018 questionnaire. There were no significant concerns.

Previous Visits/Concerns:
The 2012 visit was graded as B1: satisfactory.

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: The Trust induction for F1 trainees lasted for a week and was said to be comprehensive but over-long. Local induction was provided by Dr Kelly and covered the rota, trainees' roles, patient flows, a tour of the hospital and a meeting with staff. The content was reported to be very thorough and well-paced. Late starters had a 1:1 induction.
CT: CT said that they received a comprehensive one-day induction. This covered clinical information, and covered referral pathways. These were reported to be a little confusing as patients were referred onwards to either South Eastern HSC Trust (SEHSCT) or Belfast HSC Trust (BHSCT) depending not only on their medical conditions but also on other circumstances.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
F1: Trainees reported that there was always a CT or specialty doctor on their ward, and that the consultants called in to the wards often. They were well supervised out of hours by the CT trainees.
CT: Trainees said that they were normally well supervised by consultants both in and out of hours.
When a consultant was off on leave, it was not always clear who was responsible for their inpatients. Trainees felt that there needed to be a better-structured plan in these situations, so that they knew whom to contact for advice.

Handover (R1.14)
There is a morning handover which is attended by F1s, CTs and consultants. There is a post-take ward round that can extend to the shift change at 10.30am. The evening handover is at 9.30pm, attended by F1s and CTs. There is a Friday lunchtime pre-weekend handover attended by trainees and consultants. Patients were often transferred out to other units e.g. for STEMI care and repatriated back to LVH for ongoing care. Patient flows were managed by the bed manager and there is an EDAMS system, which works well.

Practical Experience (R1.19)
F1: Trainees are rotated through five ward areas on a weekly basis. Trainees said that this provided a good breadth of experience. They joined the morning consultant or CT ward round, reviewed patients under supervision, did ward jobs (one to six discharge letters per day) and had some opportunities to do practical procedures. Nurses did many of the blood tests and often attempted IV cannulation, so there were fewer tasks of no educational benefit for F1s. Trainees said that compared to Ulster Hospital, Dundonald (UHD) or BHSCT, they were learning more and being included in the medical team.
CT: CT trainees rotated weekly but could often be in a particular ward for longer than that. They could swap ward rotations if they had a particular subspecialty interest. The ACCS trainee was placed mainly in MAU and CCU to gain relevant experience. Trainees attended consultant ward rounds twice per week and did their own review ward rounds. They did not do any "F1 tasks". There were few opportunities to do practical procedures due to the acuity of most patients, so they took turns between them to access LPs, pleural and ascitic taps (about one per month each). CTs were assigned to do a week of clinics (up to 15 clinics in six months). They attended cardiology, endocrine,

gastro, and chest pain clinics, where they saw new and review patients and discussed them with the consultant. They reported that there were no issues of space at clinic and that they were well supported there.

Workload (R1.7, 1.12)
F1: Trainees said that daytime workload was steady and manageable. The out of hours work could be busy but was also manageable.
CT: CT trainees said that their workload was "just right". The evenings could be busier if there was no staff grade cover between 5.00pm-9.00pm. The weekends were of low intensity as the ED was closed.

EWTR Compliance (R1.12e)
The F1 rota was said to be Band 2b.

Hospital and Regional Specialty Educational Meetings (R1.16)
F1 trainees said that the local teaching provided was "fantastic". There is bleep-free teaching all morning on Wednesdays, which includes x-ray teaching. Trainees take part in the teaching on a rota and are given feedback for their portfolios. The whole team attend teaching.
CT trainees and the ACCS trainee were able to attend regional meetings without too much difficulty.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)
There is an on-site computer room and library. Wi-Fi facilities were satisfactory.

Quality Improvement and Audit (R1.3, 1.5, 1.22)
Trainees do QI/audit in UHD.

Patient Care (R1.1, 1.3, 1.4)
Trainees said that in their opinion the quality of patient care was very good. They were able to provide continuity of care in their work once patients had moved out of MAU.

Patient Safety (R1.1-1.5)
F1 trainees reported that they had not been shown how to use the Datix 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)
Dr Kelly was the Educational Supervisor (ES) for all the trainees. Educational supervision was said to be good and well-organised. Trainees could do ACATs at the post-take round. It was not always easy to get DOPS completed by consultants.

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

Feedback on Performance, Development and Progress (R3.13)
Trainees reported that they received regular feedback from consultants e.g., at the post-take ward round. Dr Kelly regularly asked them for feedback at the weekly teaching.

Trainee Safety and Support (R3.2)
No concerns.
There was good support from Dr Kelly and the nursing staff were said to be very helpful.

Undermining (R3.3)
No concerns.

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)
There are a small number of recognised trainers. Trainers reported that to their knowledge, their educational roles were not formally incorporated in job plans. They were appraised annually as part of HSC appraisal, although Dr Kelly was also separately appraised as FPD by Dr Renfrew, the DME. Trainers had been encouraged and supported to gain Trainer status, and there was good administrative support from the Trust.

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 findings of this visit were very positive. The visit team are aware that this is in great part due to the central role of Dr Kelly in the educational supervision, teaching and appraisal of trainees. The department should consider how she could be supported more in this role by colleagues, and plan for eventual succession in the future.

Areas Working Well

1. Trust and Local induction is efficient and comprehensive.
2. Clinical supervision is good.
3. F1 overall experience is good and the trainees feel part of a team.
4. The ACCS placement is targeted to training needs.
5. CTs get good access to outpatient clinics.
6. Local teaching is good.
7. Educational supervision is good.
8. There is good support from nursing staff.

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

There were no areas of good practice identified.

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. Trainees reported that current referral pathways can be confusing and would benefit from made much clearer.		✓	Green
2. Clinical Supervision. When a consultant was off on leave, it was not always clear who was responsible for their inpatients. Trainees felt that there needed to be a better-structured plan in these situations, so that they knew whom to contact for advice.		✓	Green
3. Trainer Support. The workload for educational supervision falls upon one Trainer. This role should be spread amongst the consultant team.	✓		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**
There were no areas of concern identified.		

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**
There were no areas of significant concern identified.		

Summary Rating Outcomes		
Red	**Amber**	**Green**
0	0	3