NIMDTA
Educational Monitoring Visit to Trust

FINAL REPORT

Hospital Visited	**Downe Hospital, South Eastern Trust**
Specialty Visited	**General Medicine**
Type of Visit	**Cyclical**
Trust Officers with Postgraduate Medical Education & Training Responsibility	**Dr X, Associate Medical Director** **Dr X, Clinical Director** **Dr X, Education Lead** **Mr X, Business Partner - Medical and Dental Workforce**
Date of Visit	**26th November 2020**
Visiting Team	**Dr X, Associate Dean for Deanery Visits, NIMDTA [Chair]** **Dr X, Head of School, Medicine** **Mr X, Lay Representative** **Ms X, Quality Management Executive Officer, NIMDTA**

Rating Outcome	**Red**	**Amber**	**Green**	**White***
	0	4	0	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 a cyclical visit to assess the training environment and the postgraduate education and training of trainees in General Medicine training at Downe Hospital.
Circumstances of this visit	The Deanery Visiting Team met with educational leads, trainees and trainers in General Medicine at Downe Hospital via Zoom.
Relevant previous visits	Triggered Monitoring Visit to General Medicine, Downe Hospital, 3rd June 2011
Pre-visit meeting	26th November 2020
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 and subsequent Trust Action Plan – 03 June 2011 Trust Background Information Template Pre-visit SurveyMonkey® November 2020 GMC National Training Survey 2019 Minutes of NIMDTA meeting with trainees allocated to General Medicine at Downe Hospital - 25 June 2018
Types of Visit	<u>Cyclical</u> Planned visitation of all Units within 5 years <u>Re-Visit</u> Assess progress of LEP against a previous action plan Decision at Quality Management Group after grading of cyclical visit Reconfiguration of Service <u>Problem-Solving Visit</u> 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.**

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

- **<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 X, Educational Supervisor (deputising for Dr X, Educational Lead)			
Trainees Interviewed			
	F1, F2, GPST	**ST1/2, IMT1/2 etc**	**ST3/4+**
Posts	3 x F2, 1 GPST	4 IMT	0
Interviewed	2 x F2, 1 GPST	1 IMT1	0
Trainers Interviewed			
Trainers x 3			
Feedback provided to Trust Team			
Dr X, Associate Medical Director Dr X, Education Lead Mr X, Business Partner - Medical and Dental Workforce			
Contacts to whom the visit report is to be sent to for factual accuracy check			
Dr X, Associate Medical Director Dr X, Education Lead			

Background

Organisation: The Downe Hospital has medical inpatient beds. There is currently no A&E based at this hospital, and limited anaesthetic support. Therefore, acutely unwell patients are not admitted directly to this hospital and anyone developing an acute medical issue tends to be transferred to the Ulster Hospital Dundonald. The post offers appropriate Care of the Elderly/Geriatric training to fulfil the new IMT curriculum requirements.

A number of consultants from other sites within the Trust attend during the week to deliver outpatient clinics.

Staff: 4 x 1.0 WTE consultants and 1 x 0.6WTE consultant, 4 x Associate Specialists/Staff Grades, 1 x GP trainee, 4 x IMT (1including 1 LTFT 60%) and 3 x F2 trainees.

Rotas: Dr X advised that there is a split rota made up of F2, IMT, GP, IMT2 Trainees, and Locums. There are no F1 trainees. The rota has changed recently to account for sickness/ low staffing levels during Covid19. It is reported to be working well.

Other Sites: All clinical activities are on Downe Hospital site. There are close links with the Ulster Hospital Dundonald, with transfers of patients between sites where appropriate

NTS: 2019; concerns highlighted in regard to feedback, adequate experience and curriculum coverage.

Previous Visits/Concerns: The visit on 03 June 2011 highlighted areas of improvement in relation to F1 training (F1 trainees are no longer posted to Downe Hospital) and requested that written guidance and specific training be given to trainees involved in the transfer of patients between sites.

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) Trainees reported that Trust induction was good, and that they had received access to online information. Local induction was very comprehensive and included an outline of their duties, cross-cover arrangements and a tour of the department. It was

noted that there had previously been a timetabled full induction prepared but due to service pressures during covid19 this was not feasible to be delivered and had been condensed down. One trainee that was on nights did not receive local induction. Trainees that were not familiar with eDams, would have welcomed an introduction to this IT system. There were no difficulties getting swipe cards or passwords.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15) Supervision from consultants at clinics was reported as good, but this does depend on the level of each consultant's involvement and interest. Consultants could be contacted easily for advice on their patients even when they are not onsite. There were no concerns regarding consultant cross cover. The absence of middle grade doctors at ward level leaves a gap, which requires the more junior trainees having to seek the consultant directly for advice on even minor queries. At no time are F2 doctors the most senior doctor's onsite. They are always buddied with a more senior doctor and never with another F2.

Handover (R1.14) There is a daily morning and evening formal handover and a longer more detailed pre-weekend handover every Friday.

Practical Experience (R1.19) There is no F1 trainees in this area. As a result locum doctors have been put in post to carry out a range of jobs in the wards, to enable F2 trainees to focus on aspects of the post that are more educationally relevant. In practice however the task orientated aspects of this post are shared equally between both the F2 trainees and the locum doctors. This is having a negative impact on F2 training.

All trainees attend ward rounds regularly, split up into the four consultant teams, where one or two would join the ward round in the morning and then complete tasks in the afternoon.

Trainees, especially F2 trainees expressed concern related to the limited range of cases. Complex and acutely unwell patients are transferred to the Ulster Hospital Dundonald.

The IMT trainee found the 4-month COE attachment to be of good educational benefit.

There is limited access to procedures, often LP's only. This is due to the fact that not a large number of procedures are carried out within the hospital due to the nature of the in-patient population. Procedures are supervised largely by consultants. SAS doctors are not based on the ward, but in GP assessment unit.

Trainees are allocated to clinic in preference to locums. It is particularly IMT focused.

Workload (R1.7, 1.12) Workload is not intensive. There is a good balance between training and service

EWTR Compliance (R1.12e) Rotas are reported as compliant.

Hospital and Regional Specialty Educational Meetings (R1.16) There is local teaching three days per week. The Postgraduate secretary helps to co-ordinate the timetable and circulates among the trainees at changeover. There is an endocrine teaching session on Mondays, a Grand Rounds style session with interesting cases discussed on a Wednesday and on Thursday afternoon is there is a pharmaceutical representative meeting and occasionally an external speaker.

Consultants attend where there are no conflicting service pressures with the current timetable. Thursdays have better consultant attendance especially if it is being delivered by an external speaker.

In practice, the trainees tend to lead the teaching. It is reported by the trainees that consultant colleagues rarely attend. Frequently the trainees teach themselves and it is now rare to have a guest external speaker deliver the teaching.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20) All trainees have access to educational resources. The simulation equipment is largely for the medical student's usage. Simulation was carried out previously in the clinical skills lab, there has been removal of some equipment up to the room currently in use, which is not ideal, due to lack of space. There has recently been a more suitable room in A&E identified in short stay unit.

Quality Improvement and Audit (R1.3, 1.5, 1.22) All trainees have completed a QI project. Some of the F2 trainees have had feedback from their supervisors regarding their project they delivered. There is limited input from the consultants, although they do encourage the trainees to complete them.

Patient Care (R1.1, 1.3, 1.4) No concerns identified

Patient Safety (R1.1-1.5) No concerns identified**.** All trainees know how to raise issues related to patient safety and are aware of Datix

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. Each has met with them to agree educational objectives. There are no difficulties accessing work place based assessments.

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.

Feedbacks on Performance, Development and Progress (R3.13) Trainees have opportunity to receive feedback at clinics and ward rounds from consultant supervisors. Each meets regularly with their Educational Supervisor to discuss performance, development and progress.

Trainee Safety and Support (R3.2) No concerns identified. Trainees felt well supported. All the trainees were aware of whom to contact at NIMDTA. The trainees are happy they know whom to contact also in regards to training support.

Undermining (R3.3) There were no concerns in the case of undermining or bullying towards the trainees or any of their colleagues and all trainees know whom to contact if this should arise.

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) Their educational roles are not formally included in consultant job plans. Individuals involved in training of postgraduates, undergraduates and physician associates all compete for time and opportunities. There is an eagerness to formalise what each provide in terms of education and the roles. Trainers reported that they felt supported in their educational role by the Trust. All trainers are recognised trainers. No issues encountered in securing study leave

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.

Concerns raised regards to training facilities and space allocation for developing and implementing curricula and assessment. The medical team have recently lost the use of the clinical skills lab to another department. This is a loss of a vital space, previously used regularly for teaching and training.

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)

This training environment lends itself well to the delivery of COE IMT curriculum requirements. However other trainees, particularly F2 trainees found the limited case mix and lack of acute cases restrictive to their educational development.

Areas Working Well
1. Formal twice daily handovers. **2.** Good balance between training and service. **3.** Access to outpatients for F2/IMT/GPST. **4.** Encouraging and enabling regular meetings with ES. **5.** Clinical supervision. **6.** Supportive culture. **7.** Access to study leave.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. Development of a positive culture of QiP. **2.** Access to clinic prioritised for trainees, particularly IMT.

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. Trainer Support. Educational roles formalised reflected in consultant job plans.	✓		**N/A**

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. Induction to include training on eDams for all trainees.		✓	Amber
2. Practical Experience. F2 trainees engaged in task oriented duties at ward level.	✓		Amber
3. Local Teaching. Encourage more SAS and consultant involvement in local teaching sessions.	✓		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. Facilities. Recent loss of training facilities and space – identify and secure a safe permanent space to deliver teaching and training.	✓		**N/A**
2. Clinical Supervision. SAS grade doctors to be based at ward level to offer supervision and bridge the gap between junior trainees and consultant grade.		✓	**Amber**