# LEP Action Plan to Deanery Visit Report

All final reports including the Trust action plan will be sent to the Director of Medical Education and copied to the Chief Executive Officer, Medical Director, RQIA, HSC Board, DHSSPS. Final reports and action plans with names redacted will be published on the NIMDTA website. These reports will be used to inform GMC of both good practice and areas of concern through the Dean's Report.

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| **Local Education Provider (LEP) Visited** | Altnagelvin Area Hospital | | **Factual Accuracy Report** (15 working days to respond) | **Date Issued:** 17 May 2018<br>**Date Trust Response Received:** NO TRUST RESPONSE RECEIVED |
| **Specialty Visited** | General Medicine | | **Interim Report and Action Plan Timeline** | **Date Issued:** 12 June 2018 (For Response by: 03 July 2018)<br>**Date Trust Response Received:** 02 July 2018<br>**Date Reviewed at QM:** 09 July 2018<br><br>**Date QM Updated Action Plan Issued:** 18 July 2018<br>**Action Plan Update Deadlines:** 30 September 2018<br>**Date Trust Response Received:** 27 September 2018<br>**Date Reviewed at QM:** 15 October 2018 |
| **Type of Visit** | Cyclical | | | |
| **Trust Officers with Postgraduate Medical Education & Training Responsibility** | Dr Dermot Hughes, Medical Director<br>Dr Neil Corrigan, Director of Medical Education | | | |
| **Date of Visit** | 19 April 2018 | | | |
| **QMG Grading Decision & Date** | Red x 4<br>Amber x 3<br>Green x 4<br><br>09 July 2018 | Red x 3<br>Amber x 1<br>Green x 7<br><br>15 October 2018 | **Final Report & Action Plan** | **Date Final Action Plan Issued:** 11 December 2018<br>**Date Final Report Uploaded to Website:**<br>**Final Report Sent to:** Dr Hughes & Dr Corrigan<br>**Date Final Report Sent:** 18 July 2018 |

**Visit Team Findings against GMC Standards for Training**

| | **Educational and/or Clinical Governance** | **Area for Improvement / Area of Concern / Area of Significant Concern** (at the time of the visit) | **Areas Identified by Visit Team:** | **Trust Action Plan:** Please consider the following questions when providing a Trust action plan response:<br>1. What has been done to date?<br>2. What are you planning to do?<br>3. When will these plans be in place? | **Lead and Involved Individuals:** | **Date to be completed by:** | **QMG Comment** | **Risk Rating** | **Status** |
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| **1** | Educational and Clinical Governance | Area of Significant Concern | **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 | Sub-specialty clinics in Nephrology, Endocrinology, Rheumatology and Elderly care medicine identified for trainees to attend clinics and partake in clinical decision making. Opportunities will also be provided for trainees to improve clinic numbers in ambulatory care settings which | **Dr Girish Shivashankar and Dr Stephen Todd** | **August 18** | The Deanery QM group have requested an update on the clinic opportunities available following the implementation of the changes described. An update is requested by **30 September 2018**. | High Impact / High Likelihood | Stage 2 |

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| | | | are very unlikely to get to enough clinics to meet the mandatory requirements of their curricula.<br>This must be addressed as a matter of priority if the post is to continue to be suitable for Core Medical or GP training. | include dialysis unit, ambulatory care unit, day care unit in elderly care. Rota will be reviewed to increase clinic opportunities and NIMDTA trainees will be offered clinic experience over locums<br><br>Implement date: August 2018 to coincide with new trainees<br><br>**LEP Update 27.09.18**<br>The out-patient clinic is now part of the tier 2 rota. There is a dedicated week of out-patient clinics in medical sub-specialties on the rota. Trainees are also encouraged to attend Ambulatory care unit, day care unit and renal haemodialysis unit where they get exposed to ambulatory patients with a consultant or middle grade cover. Preference will be given to CMT/GPST/FY2 trainees wherever possible. Attached copy of rota. | | | **Final QMG Update 15.10.2018**<br>The Deanery QM group have requested that a copy of the rota is shared as this was not attached with the 01.10.18 update. QMG also requests details of the number of clinics that each GP and CMT trainee attended between August 2018 and February 2019.<br><br>This action plan is now closed and this item will continue to be monitored via the LEP Quality Report. The next update is due for submission on **Friday 29 March 2019.** | | |
| **2** | Educational and Clinical Governance | Area of Significant Concern | **Clinical Supervision.**<br>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. | This issue was resolved on the day; locum doctors (above FY2 grade) to cover Waterside hospital until a permanent replacement is found. Trust is in the process of advertising a trust grade specialty doctor to cover this position. | **Dr Girish Shivashankar and Dr Stephen Todd** | **Sorted** | The Deanery QM group acknowledge and accept the action provided. | Low Impact / Low Likelihood | Stage 5 |

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| | | | 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. | | | | | | |
| **3** | Clinical Governance | Area of Significant Concern | **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. | All junior doctors to be trained and to ensure they are compliant with any new equipment that they are not used to. This should be at induction and essential training to all new equipment when they are commissioned in the trust. Training for thios specific venepuncture kit will be offered at specialty induction and facilitated by the Nurse simulation lead at the Centre for Medical and Dental Education and Training<br><br>Time line: August 2018.<br><br>**LEP Update 27.09.18**<br>Junior doctors had induction at trust and departmental level and had familiarisation of the wards and equipment used. This is acknowledged in their induction appraisal. They have been assessed for safe and ANTT technique of venesection and cannulation. Junior doctors will be | **Dr Girish Shivashankar and Dr Stephen Todd Dr Neil Corrigan** | **August 2018** | The Deanery QM group have requested confirmation that training has been provided to all appropriate staff.<br><br>**Final QMG Update 15.10.2018**<br>The Deanery QM group acknowledge and accept the action provided and this item is now closed.<br><br>However, the Deanery QM group would remind the Trust to ensure that training is provided at induction to all new trainees at all grades. | Low Impact / Low Likelihood | Stage 5 |

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| | | | | provided training to any new equipment commissioned in the Trust | | | | | |
| **4** | Educational and Clinical Governance | Area of Significant Concern | **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. | This has been raised as a governance issue both as part of a Datix and following this report.<br>Currently the portering service does provide a security facility. The Trust will review current guidelines and advice to staff in the event of perceived or actual threat from patients.<br><br>A safety awareness session on patient threat / aggression will be included at induction including an update on local Trust procedures re same | **Dr Neil Black** | **December 2018** | The Deanery QM group thank the Trust for their response to this item. This item has been supplied for information only. A RAG rating will not be allocated and this item will be categorised as closed on the action plan. | N/A | N/A |
| **5** | Educational and Clinical Governance | Area of Significant Concern | **Undermining.** X | X | **X** | **December 2018** | The Deanery QM group have requested an update on this item by **30 September 2018**.<br><br>**Final QMG Update 15.10.2018**<br>The Deanery QM group welcome the Trust's update and encouragement to trainees to raise concerns.<br><br>This action plan is now closed and this item will continue to be monitored via the LEP Quality Report and regular discussions between the Medical Director and Postgraduate Dean. The next update is due for submission on **Friday 29 March 2019.** | High Impact / Medium Likelihood | Stage 3 |

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| **6** | Educational and Clinical Governance | Area of Concern | **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. | Clinical leads to ensure their junior doctors actively take part in clinical rounds, MDT's and teaching/educational sessions. Piloting team based junior doctor cover, where there is more collective ownership and responsibility to clinical tasks.<br><br>**LEP Update 27.09.18**<br>Clinical supervisors and specialty consultants have been notified about this issue at appropriate forum. This also has been acknowledged at the induction appraisal. The trainees will be asked for feedback during their mid-term appraisal and further progress noted. The current practice is that all doctors on the wards do the ward rounds together and share the work load. The upcoming extension of H@N and phlebotomy will reduce unnecessary tasks. | **Dr Girish Shivashankar and Dr Stephen Todd** | **February 2019** | The Deanery QM group have requested an update on progress by **30 September 2018**.<br><br>**Final QMG Update 15.10.2018**<br>This action plan is now closed and this item will continue to be monitored via the LEP Quality Report. The next update is due for submission on **Friday 29 March 2019.** | Medium Impact / High Likelihood | Stage 2 |
| **7** | Clinical Governance | Area of Concern | **Patient Care.** Trainees were concerned about the high turnover, and therefore the specialist skills, of nurses looking after cardiology patients in Ward 20. This has been shared for information only. | This is a ward specific issue, which is currently being addressed at senior management level. Share the concerns raised to relevant people with an action plan by ward manager. | | | The Deanery QM group note that this was supplied for information only therefore a RAG rating will not be allocated and this will be categorised as closed on the action plan. | N/A | N/A |
| **8** | Clinical Governance | Area of Concern | **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 been audited recently. This has been | Effective handover has been a focus of medicine and has included foundation led QI project that informed the development of an electronic handover system for information sharing. This specifically examined the issue of 'missing' patients | **Dr Neil Black** | | The Deanery QM group note that this was supplied for information only therefore a RAG rating will not be allocated and this will be categorised as closed on the action plan. | N/A | N/A |

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| | | | shared for information only. | | | | | | |
| **9** | Educational Governance | Area of Concern | **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. | Teething issues with TURAS eportfolio system led to delay last year. This is not anticipated this year.<br>This is being looked into. Education department to liaise with NIMDTA as soon as practically possible to ensure the trainees get clinical supervisors allocated on the system in a timely manner.<br>ES will get the trainees' access and do the meeting within the first few weeks. | **Dr Neil Corrigan and Dr Girish Shivashankar and Dr Stephen Todd** | **August 2018** | The Deanery QM group acknowledge and accept the action provided. | Low Impact / Low Likelihood | Stage 5 |
| **10** | Educational Governance | Area of Concern | **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. | **Funding for Phlebotomy expansion:** this will minimise the phlebotomy issues for FY1's. Early trials of same have been positively received by trainees.<br>**H@N Extension:** on its second attempted recruitment cycle – once recruitment is complete this will be extended OOH.<br>**FLOW/NOTE electronic task system:** ICT have convened a pilot within a medical ward to test the system (ward 3 respiratory). We hope to spread across the hospital once tested.<br>**Digital sign off of results in NIECR:** This month, the AMU team completed a further cycle of a QI project I started with them on results digital signoff in NIECR. Early results are very positive<br>Individual medical teams to have effective handover on Friday evenings (to do jobs and clinical reviews).<br>Adhoc out of hours job to be kept to a minimum.<br>Action plan: QIP within the next 12 months to show any progress.<br><br>**LEP Update 27.09.18** | **Dr Neil Black Dr Neil Corrigan** | **February 2019** | The Deanery QM group have requested an update on the actions taken to address the unnecessary tasks requested by nurses at the weekends for F1 trainees by **30 September 2018**.<br><br>**Final QMG Update 15.10.2018**<br>The Deanery QM Group welcomes the improvements the Trust have implemented. However, there are concerns that the solution requires F1 trainees to undertake extra shifts. The Deanery requests that the Trust consider a solution to provide this support to trainees.<br><br>This action plan is now closed. This item has been merged with existing item (QA5966) and will continue to be monitored via the LEP Quality Report. The next update is due for submission on **Friday 29 March 2019.** | Medium Impact / Medium Likelihood | Stage 2 |

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| | | | | Hospital at night, Phlebotomy services and effective handover now in place. Phlebotomy extension is now an integral part of the Winter Resilience plan, as accepted by CEO. Funds have been allocated. This means extension from 70% of wards on weekdays to 100%, new presence in afternoons as a roving team and expansion to weekends and bank holidays.<br>Extra shifts are being offered to FY1 doctors at holiday weekends to reduce burden on those on duty. Phlebotomy cover also reduces burden and allows the doctors to cover more educationally rewarding tasks.<br>We are gearing up to pilot Flow/Note Tasks for phlebotomy requests in ward 3 soon. The plan is to cover the whole hospital, so they can see demand on a day and allocate staff accordingly. | | | | | |
| **11** | Educational and Clinical Governance | Area for Improvement | **Induction.** Ward induction for foundation doctors is variable. An introductory tour of the department would be beneficial and should be built into future inductions. | Departmental inductions to be part of all medical specialties and duly noted in initial appraisal meeting with clinical supervisors.<br><br>**LEP Update 27.09.18**<br>The junior doctors had mandatory Trust induction as well as departmental induction. This included tour of the wards, familiarisation with the equipment and duly acknowledged in the induction appraisal. | **Dr Girish Shivashankar and Dr Stephen Todd** | **August 2018** | The Deanery QM group have requested confirmation that a consistent induction, including a tour, has taken place for foundation doctors in August 2018.<br><br>**Final QMG Update 15.10.2018**<br>The Deanery QM group acknowledge and accept the action provided. | Low Impact / Low Likelihood | Stage 5 |
| **12** | Educational Governance | Area for Improvement | **Educational Resources.** Trainees have difficulty accessing simulation opportunities. We would encourage developments in this area to continue. | Simulation teaching and training arranged to cater to CMT/GPST needs. This initiative is taken up Dr Horan along with education leads Dr Shivashankar and Dr Todd.<br>Similar teaching to include foundation grade doctors. | **Dr Neil Corrigan Dr Paul Baylis** | **August 2019** | The Deanery QM group acknowledge and accept the action provided. | Low Impact / Low Likelihood | Stage 5 |

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| **13** | Educational and Clinical Governance | Area for Improvement | **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. | The medix (abbreviated Datix) form will be rolled out across the Trust in a planned QI project this year – a QI project in SWAH last year provided proof of concept for this project | **Dr Neil Corrigan** | **August 2019** | The Deanery QM group acknowledge and accept the action provided. | Low Impact / Low Likelihood | Stage 5 |
| **14** | Educational and Clinical Governance | Area for Improvement | **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. | Further work by CMDET to promote specific trainee identification<br><br>**LEP Update 27.09.18**<br>All the senior and nursing staff has been notified of this issue at appropriate forum. Posters are in place across the Trust. Lanyards with appropriate grades are supplied to trainees at induction and nursing and allied staff encouraged to use the right designation for junior doctors. This will be further monitored during their mid-term and end of attachment appraisals. The issue of clarity around junior doctor nomenclature remains a challenge with to date no system that translates easily to patient understanding. | **Dr Neil Corrigan** | **August 2019** | The Deanery QM group have requested an update on this item by **30 September 2018**.<br><br>**Final QMG Update 15.10.2018**<br>The Deanery QM group acknowledge and accept the action provided, and encourage the Trusts to continue to promote junior doctor nomenclature. | Low Impact / Low Likelihood | Stage 5 |

## Good Practice Items / Areas Working Well from Visit Report [if applicable]

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

| **Areas Working Well** |
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| **1.** Trust induction is comprehensive; badges and passwords are provided in a timely manner.<br>**2.** Clinical supervision is good in Altnagelvin Hospital, particularly out of hours.<br>**3.** The H@N handover works well. F1s can present patients at the meeting.<br>**4.** F1 trainees are well supported by the H@N team.<br>**5.** F2 and CT trainees do admission shifts in ED, which allows them to clerk in patients and initiate management. |

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| **6.** Local teaching is generally of a good standard.<br>**7.** Trainees appreciate the provision of accommodation or a travel allowance by the Trust.<br>**8.** Clinical and educational supervisors are motivated, trained and well supported. |

**Impact, Likelihood & Risk**

The above points have been graded by the Quality Management Group in accordance with the GMC's risk and status ratings below.

**'Impact'**

Impact takes into account:

- Patient or trainee safety.
- The risk of trainees not progressing in their training.
- Education Experience. For example, the educational culture, the quality of formal / informal teaching etc.

An issue can be rated high, medium, or low impact according to the following situations:

*High* Impact: patients or trainees within the training environment are being put at risk of coming to harm. Or trainees are unable to achieve required outcomes due to poor quality of the training posts / programme.

*Medium* Impact: trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement. Or patients within the training environment are receiving safe care, but the quality of their care is recognised as requiring improvement.

*Low Impact*: issues have a minimal impact on a trainee's education and training, or the quality of provision for the patient.

**'Likelihood'**

Likelihood measures the frequency at which issues arise. For example, if a rota has a gap because of one-off last minute sickness absence, the likelihood of issues occurring as a result would be low.

*High Likelihood*: the issue occurs with enough frequency that patients or trainees could be put at risk on a regular basis. What is considered to be 'enough frequency' may vary depending on the issue. For example, if rotas have consistent gaps so that there is a lack of safe cover arrangements, the likelihood of issues arising as a result would be 'high'.

*Medium Likelihood*: the issue occurs with enough frequency that if left unaddressed could result in patient safety issues or affect the quality of education and training. For example, if the rota is normally full but there are no reliable arrangements to cover for sickness absence, the likelihood of issues arising as a result would be 'medium'.

*Low Likelihood*: the issue is unlikely to occur again. For example, if a rota has a gap because of several unexpected sickness absences occurring at once, the likelihood of issues arising as a result would be 'low'.

**'Risk'**

Risk if then determined by both the impact and likelihood and will result in a RAG rating according to the below matrix:

**Risk Rating**

| **LIKELIHOOD** ↓<br>**IMPACT** → | LOW | MEDIUM | HIGH |
|---|---|---|---|
| LOW | GREEN | GREEN | AMBER |
| MEDIUM | GREEN | AMBER | RED |
| HIGH | AMBER | RED | RED |

**Status Ratings**

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| Stage 1: **NEW CONCERN IDENTIFIED** - a concern has been identified and an action plan is not yet in place. |
| Stage 2: **PLAN IN PLACE** - an action plan for improvement is in place but has not been fully implemented and evaluated. |
| Stage 3: **PROGRESS BEING MONITORED** - there is continuing monitoring and evaluation of actions but no evidence of change has been demonstrated. |
| Stage 4: **CHANGE SUSTAINED** - actions have been implemented and there is evidence of improvement through monitoring. |
| Stage 5: **CLOSE CONCERN** - solutions are verified or there is evidence of sustained improvement over an appropriate time period. If this is an open item on the GMC Dean's Report, a request will be made to the GMC to close the concern. |

**New GMC Standards for Medical Education and Training [Promoting Excellence - Jan 2016]**

| **Theme 1:** Learning Environment & Culture | **Theme 2:** Educational Governance & Leadership | **Theme 3:** Supporting Learners | **Theme 4:** Supporting Educators | **Theme 5:** Developing and Implementing Curricula and Assessments |
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| **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.<br><br>**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. | **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.<br><br>**S2.2:** The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety.<br><br>**S2.3:** The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity. | **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. | **S4.1:** Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.<br><br>**S4.2:** Educators receive the support, resources and time to meet their education and training responsibilities. | **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. |

| **Additional Comments from the Trust:** | |
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| **I would like to thank Dr John Corrigan for his hard work and dedication as educational lead over the past years and wish him well in his new job outside the Trust. I would also like to welcome Dr Stephen Todd and Dr Girish Shivashankar as the new educational leads for CMT and HST respectively. Both have contributed to the solutions and improvement to training and induction outlined above. I look forward to supporting training within medicine led by two able and enthused educators.** | |
| **On Behalf of the Trust: Director of Medical Education** | **Signature:**  <br>**Date: 27/09/2018** |