NIMDTA
Deanery Visit to Southern Trust

FINAL REPORT

Hospital Visited	**Daisy Hill Hospital, Southern Trust**
Specialty Visited	**General Medicine**
Type of Visit	**Cyclical visit**
Trust Officers with Postgraduate Medical Education & Training Responsibility	Mr Colin Weir, AMD Education and Training Dr John Harty, Education Lead, DHH
Date of Visit	**30th April 2018**
Visiting Team	Dr Richard Tubman, Associate Dean (Chair) Dr Janet Harding, Deputy Head of School, Medicine Dr Ali Rodgers, GP Representative Dr Laurence Burke, Foundation Representative Dr Mumtaz Patel, External Representative Mr Peter Somerville, Lay Representative Dr Eimear McCorry, Trainee Representative Ms Jo-Anne Cairns, Hospital Executive Officer, NIMDTA
Rating Outcome	**Red**: 2 · **Amber**: 2 · **Green**: 4
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 Daisy Hill Hospital.
Circumstances of this visit	The Deanery Visiting Team met with educational leads, trainees and trainers in General Medicine at Daisy Hill Hospital.
Relevant previous visits	Cyclical visit to General Medicine, Daisy Hill Hospital, 22nd 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 22nd November 2012 and subsequent Trust Action Plan Trust Background Information Template 15th March 2018 Pre-visit SurveyMonkey® April 2018 GMC National Training Surveys 2017 Trainee verbal feedback to NIMDTA Roadshow 18th April 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 John Harty, Foundation Programme Director
Dr Bronagh McGleenon, Foundation ES
Mr Simon Gibson, Assistant Director Medical Directorate *(via video link)*
Mrs Kelly Wylie, Medical Education Coordinator *(via video link)*

Trainees Interviewed

	F1	F2	CT1/2, GPST, ST1-2	ST3+
Posts	8	3	8 CT1/2, 5 GPST, 1 ACCS ST1	1
Interviewed	7 (current and past F1)	3 (current and past F2)	6 CT1/2, 3 GPST, 1 ST1	1

Trainers Interviewed

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Feedback provided to Trust Team

Dr John Harty, Foundation Programme Director
Dr Ahmed Khan, Acting Medical Director
Dr Shane Moan, Clinical Director
Mr Simon Gibson, Assistant Director Medical Directorate
Mr Shane Devlin, Chief Executive *(via video link)*
Mrs Kelly Wylie, Medical Education Coordinator *(via video link)*

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

Dr John Harty, Foundation Programme Director
Dr Shane Moan, Clinical Director

Background

Organisation:
Daisy Hill Hospital (DHH) is a busy District General Hospital. Most undifferentiated medical patients are admitted through the emergency department. There are subspecialties in Cardiology, Gastroenterology, Respiratory Medicine, Care of the Elderly/Stroke/Rehabilitation, Diabetes/Endocrinology and Nephrology. There are three general medical wards and a stroke/rehab ward, and care is provided on a ward-based system. There is a High Dependency Unit (HDU) which is covered at night by medical trainees.
The first tier at night is an F1 full shift. The second tier at night is made up of an F2 and a CT trainee (never two F2 trainees). There is a full shift third tier at night which is variably filled by the ST3+ trainees and locums. The visit team were told that currently 84% of this rota has been filled. Specialty doctors are on an evening rota until 9.00-9.30pm.
Staff:

There are 13 consultants (including three locums) across the range of sub-specialties but all participate in the general take-in. There are nine associate specialist/specialty doctors. Training posts in Medicine include one ST3+, one ST1 (ACCS), eight CT1/2, five GPST, three F2 and eight F1.

Other Sites: N/A

NTS: 2017
There were green indicators for reporting systems in CMT and for educational governance in F2.
There were red indicators for study leave in GPST; for handover, induction and study leave in F2 and for workload in F1.
There was an 83% response to the trainer survey, with a red indicator for handover.
The 2018 NTS was open during this visit.

Pre-visit SurveyMonkey:
There were 20/26 (77%) responses to the April 2018 SurveyMonkey questionnaire.

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)
Trust induction
F1 trainees had a three-day initial induction, with general Trust induction on the first day and ILS and other training on the third day.
Trainees said that there were no difficulties getting passwords and ID badges unless they started on nights.

Unit induction
F1: F1 trainees said that they received their one-year rota when they started in post.
F2, GPST: Trainees received some induction on prescribing, etc. F2 trainees had been sent some advance information but GPST trainees had not. GPSTs said that they were given their rota when they arrived. Trainees who did not know that they could email the rota organiser in advance about their rota requests were disadvantaged. Trainees said that those who were rostered to be off at the time of induction did not get an induction later.
CT/ST: Trainees said that they received a number of talks and specialty information at the start of the post. However their duties were not explained very well and there was no tour of the department. Trainees also said that those who knew could contact the rota organiser in advance, but this led to inequity of leave allocation.
The reason for not receiving advance information was said to be because "NIMDTA had not given Daisy Hill a list of names of trainees". Trainees said that they "were made to feel that it was our fault" that this happened.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
F1: F1 trainees said that they were well supervised at all times and that in particular support was very good out of hours. There was variable registrar-grade cover at night.
F2/GPST: F2 trainees confirmed that they were never the most senior doctor in the hospital at night.
GPST trainees said that as there was sometimes no registrar-grade doctor on overnight, they would be the most senior trainee in the hospital. This could be challenging particularly as they covered HDU patients at night. They would have to phone the on-call consultant a lot. They appreciated the presence of the specialty doctor between 5.00-9.00pm, and they said that consultants came in readily when requested.
CT/ST: Trainees reported that consultants were approachable and available at all times. They reported that patients in HDU were often very ill and frequently needed more specialist advice, but that registrar-level cover was variable and dependent on locums. They reported that they were asked to prescribe drugs that they were not familiar with,

such as inotropes.

Handover (R1.14)
There is a 30 minute morning handover at 9.00am attended by all trainees. It is led by an associate specialist, and was said to be well organised and structured, but mostly business-orientated. There is an evening Hospital At Night (H@N) handover at 8.30pm. There is a Monday morning handback meeting at 8.45am attended by consultants, but trainees said that it was of no educational benefit to them. There is a Friday afternoon handover meeting in preparation for the weekend.
Trainees said that there was a variable handover from ED about patients being admitted to the wards. They reported that occasionally patients would be "missed" in the wards and their care delayed. A number of examples of this were given by trainees. These were reported to have been dealt with through IR1 and M&M meetings.
Trainees also reported that at times they did not have adequate information about elective patients being admitted, which also delayed their care.

Practical Experience (R1.19)
F1: F1 trainees said that in their opinion their experience in DHH was better than in some bigger hospitals. F1s said that the reorganised system worked well and that they could work with the F2 and CMT trainees as a team and share tasks. They had opportunities to manage unwell patients. They could attend consultant ward rounds if not too busy. They did not clerk in patients during the day but so did out of hours. They did a variety of ward based tasks including phlebotomy (there is no phlebotomy service but some nurses and HCAs take blood), eight to ten discharge letters per day, and some practical procedures including LP, insertion of nasogastric tubes, joint aspiration etc. They had some support from pharmacists on the wards.
F1 trainees did not work from a ward book except in Stroke/Rehab. They said nurses in the other wards came directly to them about tasks and explained why they needed to do them. Stroke/Rehab was covered by the surgical F1 trainee who was said to "dip in and out and just do the jobs" there.
F2/GPST: F2 trainees joined consultant ward rounds on Monday/Wednesday/Friday mornings. They said that although consultant ward rounds were meant to be staggered, it could be challenging when several arrived in the ward at the same time. The post-take consultant's ward round took priority. The other consultants would write instructions in the patient notes, and F2s said that they could phone the consultant without problem if they were not sure what was expected. F2 trainees did their own ward rounds on Tuesday/Thursday. They had opportunities to do practical procedures such as LP and paracentesis and were supervised well. They said that they were not rostered for clinics, and although there was potential to attend they were too busy.
GPST trainees said that they very rarely got to clinics and if they did attend it was in their own time.
CT/ST: Trainees reported that there was a varied medical take-in with a wide case mix and good access to practical procedures. They said that the ward-based system was better although they did move between wards quite frequently. They took part in consultant ward rounds and did their own. They were able to present patients to consultants and receive feedback.
CTs said that they were not rostered to attend clinics and their workload in the wards did not allow them to get to them very often. Trainees said they had been to 0-3 clinics each since February. The ST3+ trainee however was able to attend many outpatient clinics.

Workload (R1.7, 1.12)
F1: Trainees reported that their workload during daytime and week nights could be busy but was generally manageable. Workload at weekends was very busy with multiple small tasks, and trainees said that sometimes it felt like they were cutting corners, particularly as the number of F1 posts had been reduced by one this year.
F2/GPST: Workload was said to be variable depending on the ward, and on how many medical outliers there were. Weekend work was busy but manageable.
CT/ST: Trainees reported that workload could be very busy out of hours with 20-25 admissions at that time. They said that although it could be intense it provided good learning opportunities.

EWTR Compliance (R1.12e)
Trainees reported that their rotas were compliant, although F1 had gone from Band 1a to 2b. F1s said that they sometimes got away 30-60 minutes after their shift ended.

Hospital and Regional Specialty Educational Meetings (R1.16)
There is medical teaching on Tuesdays and Thursdays. This comprised peer-peer teaching with consultant supervision and feedback and was said to be of good quality and relevant. There is F1 teaching on Wednesdays

alternating with postgraduate medical teaching. Trainees said that they were able to attend about 50% of local teaching.
F2 trainees were generally able to attend generic skills teaching at NIMDTA and GPST could attend training days in Craigavon Area Hospital. F2 and GPST trainees said that they got their mandatory training timetables well in advance from NIMDTA. There had been some difficulties initially with the video link used to join regional teaching meetings but this had been resolved.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)
There is good provision of Wi-Fi and ICT. There are no simulation training opportunities in DHH.

Quality Improvement and Audit (R1.3, 1.5, 1.22)
Trainees said that they were able to avail of opportunities to take part in QI and audit.

Patient Care (R1.1, 1.3, 1.4)
Trainees said that in their view the quality of care provided to patients was very good-excellent. F1 trainees said that the ward-based system allowed them good continuity of care (apart from in Stroke/Rehab), but this was not the experience of F2/GPST trainees who said that they were in a different ward each week.

Patient Safety (R1.1-1.5)
Trainees were encouraged to report any concerns that they had about patient safety or clinical care. F1s were unsure how to use the Datix system. There were some concerns that the GPST or CTs were at times the most senior trainees in the hospital at night, particularly in light of HDU cover.

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 access to their named educational supervisor. There are no difficulties in accessing workplace-based assessments. CTs said that they are able to do ACATs on post-take ward rounds.

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 said that they received regular informal feedback on their clinical performance.

Trainee Safety and Support (R3.2)
No concerns reported.

Undermining (R3.3)
There were no specific instances of undermining reported. Trainees said that on occasions there was a lack of sympathy and understanding by some members of the middle tier about how much pressure trainees were under due to staffing issues and the workload out of hours.

Study Leave (R3.12)
Trainees reported that organising study leave could be very difficult, and this was confirmed by trainers. Only two trainees were allowed off at a time because of the tight rotas, and annual leave got precedence over study leave. CT and STs described study leave opportunities as "an absolute nightmare". Some had stopped requesting study leave because they saw no point in trying.

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 their educational roles were including in job plans, although the process of educational appraisal was less well developed. Trainers had been supported to complete the training required for Recognition of Trainer status.

Trainers reported that they had limited resources for training in DHH and in particular the infrastructure was poor – there was no education centre and clinical space was limited. There was the perception that some in managerial roles the Trust saw medical education as of little importance compared to service, e.g. a comment "why are the juniors going to teaching?" was made to one of the trainers.

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)

The visit team acknowledge the efforts made by Trainers in DHH to provide a good standard of medical education in the face of ever-increasing clinical pressures and staffing difficulties. In particular we would like to commend Dr John Harty for his input and dedication.

Areas Working Well

1. There is a wide case mix of clinical conditions and opportunities for practical procedures in DHH.
2. The experience of F1 is generally good. They feel included in a team.
3. The reorganised system of care was seen as an improvement over the former system.
4. Senior medical staff are committed to education and are supportive of trainees.
5. Clinical supervision is generally good.
6. Educational supervision works well.
7. There is a regular programme of teaching.
8. Morning and evening handover meetings are well-organised.
9. There is a culture of patient safety within the department.

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 their unit induction could be improved, with clearer explanation of their duties, and a tour of the department. This is particularly important for trainees who have not worked in DHH before. We	✓	✓	Green

	Educational Governance	Clinical Governance	RAG
would encourage a review of the content and relevance of the unit induction process.			
2. Induction. Trainees who start out of synch (e.g., rostered to be off or on nights) should be provided with a unit induction in a timely manner.	✓	✓	Amber
3. Educational Resources, Internet Access, Simulation Facilities. There are no opportunities for in situ simulation, such as team-based drills or human factors training.	✓	✓	Amber
4. Practical Experience. There is no phlebotomy service. Introduction of one particularly at weekends would reduce the burden of non-educational tasks for F1 trainees.	✓		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. Induction. Trainees who have worked in DHH before know to email the rota coordinator with their leave requests in advance, whilst trainees coming from elsewhere are necessarily disadvantaged. This inequity in leave allocation must not continue. This can be resolved by better communication between all parties involved in making and sharing trainee allocations and planning rotas locally.	✓	✓	Amber
2. Clinical Supervision. The third tier (registrar-grade) out of hours rota depends heavily on locums and is not always filled. CT or GPST trainees are then the most senior doctors in the hospital at night. They are responsible for patients in HDU which can be outside their level of experience/competence.	✓	✓	Red
3. Handover. Trainees said that there was a variable handover from ED about patients being admitted to the wards. They reported that occasionally patients would be "missed" in the wards and their care delayed.	✓	✓	N/A
4. Practical Experience. CT and GPST trainees rarely attend outpatient clinics. There is a curriculum requirement for CTs to attend clinics; therefore this must be addressed as a matter of priority. Clinic attendance might be improved by formally rostering CTs and GPSTs to a clinic week or similar arrangement.	✓		Red
5. Study Leave. Access to study leave is very difficult due to rota pressures.	✓		Red
6. Trainer Support. Trainers reported that they had limited resources for training in DHH and in particular the infrastructure was poor – there was no education centre and clinical space was limited.	✓		N/A

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):

There were no areas of significant concern identified.

Summary Rating Outcomes

Red	Amber	Green
2	2	4